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THE MEDICAL JOURNAL OF AUSTRALIA

Vol. II.—14th Year. SYDNEY: SATURDAY, DECEMBER 31, 1927. No. 27.

Index to Advertisements

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An Address.[1]

By H. V. FOXTON, M.B., B.S. (Melb.),

Retiring President, Queensland Branch of the British Medical Association.

IN addressing you tonight it is my intention to touch briefly on just a few of the many subjects which may give food for reflection to the President of a Branch during the tenure of his office and if any opinions expressed by me have the effect of inducing members of the Branch to give more thought to the matters touched on, I shall feel that I have done some service.

The Relationship of the Profession to Hospitals.

Perhaps the most important matter at the present time and one that is going to be of even greater moment in the future is the relation of medical men to public hospitals and to the various classes of patients who attend the public hospitals. But this question is as yet in such a nebulous state and beset by so many conflicting issues and points of view that clear-cut conclusions are not easy to arrive at. Two things stand out prominently, one, that a growing proportion of the public is attending the public hospitals each year and the other, that a point may be reached at which the burden of charitable work cast upon the shoulders of the profession may be greater than it can bear. At different times ingenious schemes have been propounded for nationalizing the medical profession and there are not wanting among us idealists to whom the thought of accepting individual payment of fees for attending the sick is repugnant. However, one rock on which any nationalization scheme would be likely to split, would be the freedom of choice of medical attendant which the sick would wish to exercise. Also we have to consider that the tendency of our race in the past has been towards a sturdy individualism which is suspicious of much State control that so often means the inefficient, if not corrupt control of a bureaucracy. The most promising suggestion to help to solve the growing problem seems to be the establishment of intermediate hospitals for the benefit of those who would find the burden of full medical and hospital fees too great, but who should be ineligible for charitable treatment. These hospitals are hardly an established fact yet and it is difficult to know to what extent it will be found practicable to develope them. In any case, it behoves the profession to take steps to see that a far more searching investigation than has hitherto been instituted should be made into the ability of such patients as apply for public hospital treatment, to pay private fees. It is common knowledge that no inconsiderable numbers of these patients are the proud possessors of motor cars and have not any of us had a confession that the reason why some patients wished to be treated at a public hospital was because of the expense of keeping a motor car? The fact that public hospitals require patients who can afford it, to pay partially at least for maintenance, seems to act as a salve to the conscience of many people who persuade themselves that such a contribution is a sufficient reward for all the attention they receive. They consider that the honorary physician or surgeon must be adequately enough rewarded since he acquiesces in the position.

It would, of course, be idle to deny that an honorary position at a public hospital has its value, as shown by the fact that such positions are sought after, but there is a gross injustice inflicted on the profession at large by persons who needlessly accept free treatment and at the same time crowd out really necessitous persons from the public hospitals. The establishment of intermediate hospitals might serve one useful purpose in educating the public to discriminate between the position of the patient who paid no professional fee at a public hospital, and that of the patient who paid his medical attendant even a small sum at an intermediate hospital.

Post-Graduate Work.

During the past few years a notable development has been the institution of post-graduate clinics. These may be regarded, in one aspect, as a recognition by the profession of the fact that if we are not going forward, we are usually going backward and that it is a duty to our patients and to ourselves to cast ourselves loose from the trammels and fetters of routine and be ever striving after fresh knowledge. It is an effort also to revive in us the keenness and enthusiasm of our student days. As these post-graduate clinics grow in their scope, one may hope, perhaps, to see regular courses of practical instruction given to medical graduates in the different public hospitals. It is sometimes remarked that our general practitioners are not alive to the benefit and stimulus to be derived from attending the large public hospitals, where they would be made welcome by the members of the staff. But general practitioners are usually busy men who have not the time to attend hospitals on the off-chance of learning something useful.

Provided the hospitals catered for their needs in a suitable manner, it is hard to believe that they would not respond. If arrangements were made for set courses of instruction to be given, the position would be made satisfactory to both parties by the payment of a fee for the benefits received; for the hospitals would be put to a certain amount of expense in the matter, such as providing facilities for the examination of patients. Medical men who took out such courses, would soon find themselves to be more efficient practitioners than their brethren who chose to vegetate and the public would be apt to notice the difference also.

In considering the movement for the provision of facilities for this post-graduate study, may we ask an apparently pertinent question: Is the movement solely to furbish up and refresh the graduate's knowledge and to acquaint him with the latest advances in medicine and surgery or is it also

[1] Delivered at the annual meeting of the Queensland Branch of the British Medical Association on December 9, 1927.

designed actually to educate him in matters which were wrongfully neglected in his undergraduate days?

It seems indisputable that inadequate early teaching is partly responsible for the need of post-graduate clinics and that if proper training were given to the undergraduate, the question would be simplified to some extent. One may face trepidation in venturing to criticize the methods of universities that have given Australia an able body of professional men, but the methods of the past continually need readjusting to the needs of the present and this readjustment seems to be lagging in medical education. Most of us who have been through the mill, are perhaps too much occupied in the struggle for existence to concern ourselves over much about the needs of those who are to come after us and so there is a tendency for the bulk of the profession to leave the question of medical education to more or less academic quarters.

Medical Education.

If the practising body of the profession had to address itself to the reform of medical education, there would not unlikely be some considerable changes and is it not time that we began to concern ourselves seriously with a matter which has such a direct bearing on the efficiency of the profession we all honour so greatly? Our younger brethren, too, would be grateful for any reforms that could help them in their practising careers.

Of the high standard of theoretical training set by our universities no one can doubt. Competent judges assess the standard as being second to none. The result may be seen reflected in many directions in the high standard of our medicine and surgery in the capital cities, in the ability of the general practitioners, in the articles contributed to THE MEDICAL JOURNAL OF AUSTRALIA and in the proceedings at our medical congresses, which such a competent judge as Osler considered to indicate "a high level of professional thought." Judged by the ultimate product the result in the past has been good, but the needs of the present call for some changes.

The medical student's practical education mainly takes place after graduation, either when he is fortunate enough to obtain a position as resident medical officer to a public hospital or perhaps during a more protracted period while he is engaged in general practice. Is there any one among us bold enough to wish to be anæsthetized by the graduate in medicine and surgery who has just received those parchment documents which the university authorities are pleased to call "presents"? Or would any of us feel easy at the thought that one of these ladies or gentlemen was about to perform an operation for, say, hernia on him? Such prospects would hardly please us, for we all know that in the acquisition of the practical side of his calling the young graduate has a very long way to go. And one cannot but think that when a graduate has bestowed on him the full rights which the State will at once grant him of a practising surgeon and physician, he ought to be able to carry out the commoner practices of his very responsible calling with confidence and in a workmanlike manner.

The problem is one that must have exercised the minds of many of our able medical teachers and it becomes more difficult of solution as new fields of medical knowledge become opened up and additional instruction of the student is made necessary. One almost expects to learn before long that one more year has been added to the length of the medical course, but one hardly expects that the executive ability of the new graduate will be greater than it is now, since the extra year would probably be given over to further theoretical instruction, possibly of a highly desirable caracter. Yet it is certain that the length of the medical course cannot be increased much more without defeating one of its objects, namely the supply of sufficient, as well as efficient medical practitioners. The situation might be bettered in several ways, in the first place by the relegation of such subjects as chemistry, natural philosophy and biology to the secondary schools. There seems to be no compelling reason why these subjects should be intruded into the medical course itself unless the inertia of the established order of things can be regarded as a compelling reason. The standard in chemistry and physics attained by the secondary school is not far short of the standard of the first year of the medical course and could easily be raised to it. Also it does not seem obvious why biology should not be taught in the secondary schools; few would object if some such subject as ancient history gave place to it.

Again, could not efficiency be increased and time saved by the teaching of subjects in their proper perspective; that is by eliminating much matter that has no practical bearing on the practice of medicine and surgery. Those of us who are not as young as we used to be, can recall the time that was wasted on the minutiæ of such a subject as anatomy and the obstinacy with with some teachers clung to the teaching of anatomy as a pure descriptive science, with no consideration for the ends to which it was to be applied.

We recall with disgust the great amount of time that was devoted to cramming us with the details of such a subject as *materia medica*, when we were required to know the actions, the uses and the preparations with doses of hundreds of drugs that no medical man ever uses in his practice.

Possibly such a futile spirit still clogs the path of the student in some of his studies. Just as the teaching in schools of dead languages has had to give place largely to more urgent subjects, so in the overburdened medical course the teaching of knowledge which has not a definite bearing on the practical side of the medical profession, might wisely be omitted and the time saved spent in the study of things that really matter, to which not nearly enough attention is now given, such as diseases of children, eye work, ear, nose and throat work and lunacy, in which examinations should be held. These subjects could be taught in a condensed and practical form, with omission of all matter that would prove useless in practice.

Too often are students referred to large textbooks prescribed for examination and are half smothered in masses of unpractical detail and statistics. In these books the sifting of the grain from the chaff would be a labour in itself, even for those in a position to do so. But for the student, such books are largely time-wasting devices and the result is seen at the time of graduation in a young man or woman whose energies have been to a certain extent misapplied. What is needed is not an effort to pack into the medical course the whole of every subject dealt with, but to eliminate everything unessential, to conduct examinations on essentials alone and to have the medical course welded into a harmonious whole without any overlapping of instruction. The time saved by such measures should give opportunity for turning out practitioners better fitted than they now are to begin their active professional career.

It is no exaggeration to state that at the present time, as in the past, most honorary physicians and surgeons at the public hospitals regard the new "resident" as one who badly needs instructing in the practical aspects of medicine and surgery; while as far as the vitally important specialties are concerned, the resident medical officer is still largely in the dark at the end of his year in hospital. How many of them could tell if a patient's vision were normal or not, whether the tension of an eye were low or high or pass an enlightened opinion if a certain severe headache were likely to be caused by eye-strain or by an intranasal condition? How many would have any conception, on looking into a nose, assuming perhaps inadvisedly that the use of a frontal mirror and nasal speculum had been acquired, whether what they saw there was normal or abnormal; or how many, if asked whether a child were suffering from adenoids, would have any alternative to the unpleasant and often terrifying procedure of palpating the post-nasal space? To illustrate the lamentable lack of training in ultranasal disease, one has only to inquire into the number of sufferers from bronchiectasis or septic bronchitis secondary to paranasal sinus infection, who have been labelled tuberculous and sent to sanatoria among genuine tuberculous patients. They are "clinically tuberculous" though no tubercle bacilli have ever been found.

In the case of mental diseases can we view complacently the fact that few of our young graduates can distinguish a patient who is dangerous to others or to himself from one who is not so? Most of us know of cases where a dangerous lunatic has been allowed his liberty until he has committed suicide or killed someone. And it is a fact that owing to lack of instruction a large number of the certificates of lunacy that are signed would not pass muster in a court of law. Medical men have sometimes found this out to their cost when prosecuted by a patient.

These are but a few of the matters of deep concern to the medical graduate and to the public among whom he practises, in which he can usually be said to be unskilled at graduation and very often more than one of the branches of medicine indicated remains a *terra incognita* to him to the end of his career.

It does not seem right that medical students should not be properly trained in the fundamentals of different vital branches of their calling, on the tacit assumption that by some means or another they will acquire the knowledge later on.

Ethical Matters.

During the present year a certain number of cases involving questions of medical ethics have been brought before the Council of this Branch. For obvious reasons complaints about fee-splitting are not likely to be made to a Branch Council, but bearing this in mind, one can safely say that in Queensland this ugly practice has rarely been indulged in. Its unfairness to the patient has been strongly and clearly expressed in our journal and it is not likely that it will have any defenders.

Some instances have occurred at different times when members, actuated no doubt by laudable and disinterested motives, have been considered to have placed their names too prominently before the public. One can sympathize with a desire which lives in all of us, to educate the public in any matters in which medical instructions would be for their benefit, and few will deny that it is unfortunate that so little instruction comes from the only people who are qualified to give it. The difficulty is that such instruction is always a professional advertisement for the medical practitioner who gives it, even though he may not intend it.

A Popular Medical Magazine.

A proposal has been mooted that the British Medical Association should produce a popular journal on health matters and that the articles should be written anonymously by the most competent men available. Such a proposal seems a sound one and the results should be good if the journal were well advertised and the matter put before the public in a manner suited judiciously to its tastes. It is not easy for the public to understand why the medical profession adopts what appears to be a conspiracy of silence on medical matters and if such a journal could be successfully launched and maintained, it would perform a great public service as well as remove much misunderstanding on the part of the public and also extricate the profession from a false position.

The objection raised that the public would not be interested unless each article were signed by a well-known medical practitioner is probably invalid. If the public were assured that every article was written by an authority selected by a council of the British Medical Association and that the views expressed had been endorsed by a council, it is hard to conceive that anything more could be required. The anonymous articles on medical subjects which appear in the lay press, seem to be read with avidity by the public. The establishment of such a popular medical journal would do a great deal more than teach the public wisdom in medical matters. It would promote better feeling among members of the medical profession itself by remov-

ing all occasion for individual public utterances with their attendant, though doubtless unintended self-advertisement. Another beneficent result one would hope for, would be the ruthless exposure of the methods of quackery and of quacks, to combat the gigantic evils of which the profession does practically nothing. In the suppression of quackery at present by legislative means we have no hope. It is a melancholy thing to find that the first concern of politicians is to catch votes and an attempt to suppress quackery on a wide scale would hardly do that; it would rather alienate many votes since an outcry would be raised that it was against the public interest for the medical profession to be made a close corporation.

We have lately had a strange exhibition of sophistry on the part of a Minister of the Crown, who declared that a layman who kept himself well informed, might be a better guide in medical matters than a qualified practitioner who allowed himself to vegetate. Also the press is so interested monetarily in the puffing of quack nostrums and sometimes in the full-page advertisements of unqualified practitioners, that its hostility would be inevitable and that would settle the matter as far as legislators were concerned. About the end of the first decade of its existence the Federal Parliament in a brave mood appointed a royal commission to inquire into the composition and cost of ingredients of the hundreds of nostrums, the monstrous claims for which were daily being published in the Australian press. The result was a large blue book, about eighteen inches long, twelve inches wide and two or three inches in thickness. It embodied the results of a great amount of work largely of an analytical character and was highly illuminating. Possibly some copies are still in existence. Apart from the preposterous and absurd claims advanced for these "remedies," the careful analyses made showed that when they were not inert, they consisted of common and cheap drugs which were retailed to the public at a huge profit. For example, a familiar hair lotion consisted of a solution of borax in weak rose water. The ingredients cost a fraction of a penny and a bottle of the lotion was sold for nearly five shillings. In another instance bread pills were sold at an amazing price. Members of the Federal Parliament appear to have received copies of the report, but, as might have been anticipated, discretion was thought the better part of valour and so to the present day the position remains much the same, perhaps it is worse. The only hope seems to be in educating the public to demand that action be taken and probably the best method of doing this is by the publication of a popular medical journal under the auspices of the British Medical Association.

Public health associations ought also to prove their *bona fides* by taking action in this matter and in collaborating with the British Medical Association they would no doubt be prepared to do so. The cancer campaign now being conducted is urgently required, but is it really as urgent as a campaign against the shameless quackery that stalks unchecked through the land?

NOTES ON DIET.[1]

By E. Sandford Jackson, M.B., B.S. (Melb.), F.C.S.A.,
Brisbane.

It is somewhat daring for a man of my years to appear before a learned body of men like yourselves who are all possessed of the very latest information about calories and vitamins and the whatnots of food and essay to present to you a paper on diet. Nevertheless, I remember long ago getting much information of practical use in relation to diet from two little books entitled "A Plea for a Simpler Life" and "Fads of an Old Physician," by Keith, M.D. Perhaps you will have patience to listen to these my utterances as the fads of another old physician. There may be here and there in what I say a word or two of wisdom which may be of use to you. Depend on it that, if this be so, the words of wisdom are not original and that I do but repeat what I have learned from someone else.

After I have said that, you will see that I lay no claim to being scientific or to holding a superabundance of scientific knowledge. It remains to be seen whether you will think that there is any evidence in what I am going to say that I have had any experience and still have any common sense.

It will be convenient, perhaps, to begin by a consideration of the composition of the human body, without even going into the elementary composition of the various tissues which all of you know as well and better than I. Consider the diversity of structures which go to make up the human frame—skin, fat, bone, muscles, tendons, nerves *et cetera*—and the diversities of their chemical composition. As they have to be built up and maintained at something approaching concert pitch, it is obvious that the food requirements for the human individual must be equally various.

I would remind you, too, that in all the ages since Adam very little, if any, change in those requirements has taken place. Though the years have passed and generation after generation has come and gone, the requirements remain the same as they were, not only in the dim, distant past when I was a boy, but going still further back, they are the same as those which were demanded by the frames of Adam and Eve. As far as I at least can see, our descendants of a thousand years to come are still likely to require exactly what we do in this generation.

There is one difference between us and dear old Adam and Eve, if the Biblical story be not entirely allegorical. They had no mother. In a sense that was to them an advantage, because as we of this day know so well, so much depends on the way in which mothers are fed during the time we occupy the somewhat cramped position which is ours during fœtal life. Adam and Eve came into this world as perfect beings, without owing anything to mothers.

If the expectant mothers of today are not fed sufficiently with materials which contain all the

[1] Read at a meeting of the Queensland Branch of the British Medical Association on November 4, 1927.

elements of the human frame, it is inevitably a poor look out for the babies they are to bring into the world. It is, too, a poor look out for the nation of which such babies are to form an integral part. Of all the considerations which are embraced in the words "antenatal treatment of mothers" this is by far the most important. They must have the right kind of food in plentiful supply. We have to see to it that their digestion is kept in such a state that it can enable them to assimilate a sufficiency to maintain their own frames and to supply building material for the frames of their unborn offspring.

Vitamins.

What are the materials necessary? They are built up of certain elements we all know—carbon, hydrogen, oxygen, nitrogen, calcium, sodium, magnesium, phosphorus, sulphur, iodine, for instance, but something else is necessary. However these may be mixed and combined with one another and however great the quantity in which each may be supplied, the result is not perfect without a due and accompanying supply of those mysterious bodies which today are called the vitamins.

It is certain, then, that the mothers of the future generation must have a plentiful supply of food containing all the elements of which a human body consists and in addition a plentiful supply of vitamins. Good old mother Nature has provided well for them. Such elements as they require are theirs to have in very many of the members of the vegetable kingdom, in the flesh of all animals or in the lacteal fluid of those which belong to the great kingdom of mammals. From some of these also can be obtained the necessary vitamins, because they exist more or less in all ordinary articles of diet. If white women and men, of course, would but keep as close to Nature in the matter of diet as the aboriginal races of Australia and the Pacific islands we should, for instance, have as good teeth as they.

The essential facts which emerge from all this are that the mother's diet must be a mixed one and that she can get what is necessary from vegetables and animals which ordinarily surround her in every direction. She ought to be able to contribute to the production of a race physically as perfect as the mothers in the Pacific islands did before the advent of white men. Yet at the present time civilized women are bringing into the world a generation of children which is anything but perfect and it is probable that its imperfections begin in or depend chiefly on certain deficiencies in the expectant mother's diet for which a stupid so-called civilization is responsible.

I know there are some among you who would be inclined to think that the suggestion that the children being born daily around us are deficient at birth is a little foolish. With your minds on the beautiful looking babies which so many of you are bringing into the world in your daily avocations, some of you may ask yourselves whether that is not a statement bordering on the ridiculous. I contend that the after history of those children in respect to their first teeth alone is a fair justification for the statement. For something to base your judgement on I ask you to read, if you can get it, a report supplied to the Education Department on the teeth of the children of this State by Mr. Haencke, the Dental Inspector to the Department. Part of his report is as follows:

> Initial inspection of the infant portion of our schools revealed the fact that 40% of the children had unmistakable abscessed teeth, whilst every third or fourth child had not a proper masticating surface and that these conditions continued and grew worse until by the time the child reached twelve to fourteen years the teeth as a crushing and masticating machine had become positively ruined in a large proportion of cases.

For the moment I am mentioning only the results of examination of infants, that means children who have only their first or milk teeth. For the development of these teeth surely the mother is chiefly responsible, because they are already in the child's jaws when it is born, ready to put in their appearance within a very few months of birth. Therefore with the expectant mother certainly lies the responsibility for nine months of laying a good foundation for all the tissues of her child, including its teeth. And after the birth of the child, if the mother nurse her child at Nature's fount, the same responsibility lies with her and the food which runs in her own blood for another ten months or so.

And Mr. Haencke has told us what happens to the teeth of Queensland babies during the first six years of their existence. There seems to me only one inference to draw, namely, that the poor quality of the structure of which their teeth is composed is due primarily to some deficiency of chemical or other constituents in the food of the expectant mother (and secondarily no doubt of course it is due to a similar deficiency in the food of the baby after being weaned).

The following information on the analysis of foodstuffs for which I have to thank Mr. Henderson, Government Analyst, is illuminating:

Average composition of wheat.

Water	13·3%
Protein	12·03%
Starch *et cetera*	68·74%
Fat	1·85%
Cellulose	2·31%
Mineral constituents	1·77%
Phosphoric acid	0·75%

Average composition of white flour.

Water	12·8%
Protein	10·8%
Starch *et cetera*	74·6%
Fat	1·1%
Cellulose	0·2%
Mineral constituents	1·77%
Phosphoric acid	0·2%

Vitamin *B* is gone.

In point of fact everything which common sense must teach us is important in the development of muscle, bone and teeth, has been reduced in quantity in the flour which forms so large a part of our dietary.

We find, for example, that wheaten flour has been deprived of two-thirds of the mineral constituents which the original grain contained, which constitutes a serious loss of bone and tooth making material. But perhaps the most important loss is that of vitamin *B*, which is spoken of as antineuritic. Its loss from our food may have an influence in creating unstable nervous systems. So far as I can learn, all vitamins—*A*, *B*, *C*, *D* and *E*—are removed either by the process of milling grain or in the process of cooking. Vitamin *D* is described as having similar properties to vitamin *A* with a kindred antirhachitic power which, like that of *A*, needs the backing of sunlight for its full development. *D* may be the most important factor of all, for all we know. As for *E*, the loss of which in the dietary of animals (rats) limits or destroys their productivity, its destruction may have some effect on birthrate in humans though we all know of more potent factors in its reduction. We refer to the various methods of race suicide.

You will notice also in the analysis of flour given above that protein has been seriously reduced, while the relative quantity of starch has been increased. The loss of protein can so easily be made up from other foods that it is not so important.

How important in their effects on the nation these changes are likely to be will be realized when you remember that flour continues to be far and away the chief of our foods, especially for those whose means are not great and especially for the young.

It may be that the mineral loss in the above analysis is more or less compensated in those of us who use our "tap" water for drinking purposes instead of drawing our supplies from the ordinary rain water tank. Authorities seem to be agreed that milk is the most important source of the calcium required and when raw the source of important vitamins.

It is important to note that of all the ingredients of wheat which are missing in our flour none are in any sense deleterious. There is no sense in deducting them.

Possibly the imperfections of new-born Queenslanders of this generation are less evident or no worse than those which exist in children of other parts of the world. For wheaten bread is still the principal food of all civilized nations and is doubtless over-refined to much the same extent all over the civilized world. Were it not, however, for other factors in our life in this country, such as abundance of sunlight and fresh air, which most people can and do enjoy in this country, our imperfections might be still greater. There is reason to believe that sunlight increases the power and activity of what vitamins exist or are left to us in our food after it has been "civilized." Yet far too many mothers take much pains to exclude sunlight both from themselves and children.

There remains for consideration the question of how far the absence of vitamins, even though it may fall short of actually producing some of our diseases, may lessen our resistance to disease. Might our children have better glandular structures and less tendency to tonsillitis, adenoids, goître and even appendicitis, if their chief food were nearer what Nature intended it to be? Might our nervous systems be more stable? These are matters for research, for, of course, they are shrouded in much uncertainty at present. I am sufficiently emphatic about the importance of an examination and survey of foodstuffs to say that the Public Health Subcommittee of the Queensland Branch of the British Medical Association should consider it frequently and report from time to time.

I have hitherto addressed you largely from the viewpoint afforded by the mother and child. The matter is of no less importance to the men and women who have not taken upon themselves the duty of increasing the population. No avoidable deficiencies in their foodstuffs should be permitted in the interests of their health and strength.

Invalid Diet.

Perhaps you are expecting me tonight to say something about the matter of dieting a sick man. So let us now turn for a while to that subject. First, however, let me say that no man can practise medicine for a long period without finding that much of what he has been taught as a student, has to be discarded. I feel sure the younger members of the profession will experience that as the years go on in much the same way, though perhaps in less degree than the older ones have done.

Here are one or two aphorisms, if I may call them so, which are perhaps worth attention.

First, much more harm has been done to patients by overfeeding them than by underfeeding them.

Second, as a rule with few exceptions the appetite of the patient is a better guide to the quantities he can digest and assimilate than the wishes either of himself or his friends.

Third, the condition of the tongue is a very fair guide as to a man's powers of digestion. But a dirty tongue is not to be taken as caused by conditions in the stomach or lower digestive canal. It is practically always due to some condition in the nose, mouth or pharynx. Nevertheless, until such condition is eliminated a man cannot be expected either to have a clean tongue, a good appetite or a digestion fit for much work.

Take enteric fever for example. Once we were taught that a typhoid patient from the beginning of his disease should be frequently fed, even every half hour, with small quantities of milk. It was considered so important to keep the patient's strength up. It would often have been much better if such a patient had been fed on water or albumin water with less milk and that only when he exhibited a desire for it. You can lay it down as a good rule in enteric fever that if you push food, whether soft or hard, before the tongue is clean, you will be increasing the risk of relapse. This is independently of normal temperature.

Diet After Abdominal Operations.

In postoperative abdominal conditions bear in mind that most patients who have been rightly operated upon, can exist upon nothing but water for long periods. One, two or three weeks for instance. It can be seldom right to operate on a patient who has been starved to death's door. Here again the best guide in the matter of what to give him is the patient's appetite. A real desire for food usually indicates a real, however slight, power to digest. Do not mistake the mere feeling of emptiness for real appetite or hunger. "Emptiness" is best met by the administration of small quantities of water or albumin water. When the patient's appetite continues to be on the upgrade, be careful about mixing fluid and solid food at first. Separate them by one hour. Nothing is more provocative of flatulence than mixing fluids with solids. This statement is not always applicable to the cast-iron stomach, but it applies to many otherwise quite normal stomachs. Caution nurses, anxious mothers and other relatives not to insist that an invalid shall swallow food whether he is inclined for it or not, just to keep up his strength. There is no good in filling the stomach with food which it does not call for. It is likely to produce flatulence, hiccup and a variety of discomforts and to delay the restoration of a stomach which may be as the result of an acute or febrile disease the subject of some catarrh or other condition which keeps its owner from being in normal health. Too few of us appreciate the benefits of abstinence from food or realize how long patients can go on water alone with benefit to themselves.

The Feeding of Infants.

The mother's milk should be used of course if possible. It is rarely impossible, if some attention is given to massage of the breast and some other means to be found in "Truby King" for instance. Failing mother's milk, cow's milk properly humanized is next best. I unhesitatingly declare myself against the use of artificial foods where it can possibly be avoided. Certainly they should never be continued long. Of course circumstances modify this opinion to some extent. My experience has been that however the infant may appear to thrive on a patent food, when the time comes for weaning or for the stopping of the bottle the difficulties are greater. Long after weaning has been more or less successfully accomplished, you may find that the child fed on patent food is very liable to have become a "food-faddist" compared with his own brothers and sisters who have been reared on human or cow's milk. Of such is the kingdom of "skinny" children. For these I know no special diet, except to give them milk, eggs, underdone meat, green vegetables, salads *et cetera*. But they are often so faddy that you may be at your wits' end to find something that they will eat. There is for this class, I think, a special virtue in the old Parrish's food, exactly why I do not know. Maybe cod liver oil would supply some deficiency, but I am fearful of its interfering with legitimate diet. Sunlight and fresh air, especially at the seaside in winter and mountain air in the summer should be advocated. I speak of Queensland's climate.

The Dietary of the Albuminuric.

After many years I still hold that it is most important to give an albuminuric patient instruction in regard to quantity rather than composition of food. Excessive use of any or all foods has to be avoided in this disease, as well as in health. It is not necessary either rigidly to exclude or seriously to reduce foods that are ordinarily regarded as nitrogenous and therefore rich in albumin. In my youth I was taught to forbid red meats. Presumably, I suppose, this was because they were considered to contain larger quantities of albumin. I can see that the same teaching is regarded as holding good today. I have never been able to see any justification for such a tenet. There is not so great a difference between red and so-called white meats in regard to the albumin contained that the former need be excluded. It is only necessary, I think, to caution against excessive use. Much the same applies to eggs. Will any of you tell me why the digestibility of soft-boiled eggs is generally commended above that of the hard-boiled? Most people hold that the latter is indigestible. Personally I get on better, if anything, with a hard-boiled egg. You will see some people who refrain from eating a hard-boiled egg from an egg cup and yet eat one or two in a salad without anticipatory fear or reminiscent regret. The egg coagulated by heat is after mastication no less digestible than one which is coagulated by the gastric juice after the opportunity of mincing it by the teeth has been lost. Maybe there is more vitamin in lightly boiled eggs.

Diabetes or Glycosuria.

I have nothing scientific at all to give you in regard to diabetes or glycosuria. The total result of my experience is that I have known a great number of men and women with sugar in their urine who appeared to derive no great harm therefrom, who lived long and useful lives after the sugar had first been detected. They were especially the fat variety of glycosurics with no tendency to progressing emaciation. I have never had to sign a death certificate for such a one. Again, sugar often disappears from a patient's urine for no obvious reason and independently of treatment.

Look at the variety of diets that have been suggested in books, none of which stands the test of the practitioner's scrutiny for any length of time. This one excludes potatoes from the dietary of his diabetics. That one recommends, on the other hand, an exclusive dietary of that tuber. The best results, if abolishing sugar from a patient's urine has really anything to recommend it much, were in a series of cases extending over some years, in which I treated the patients with a diet consisting exclusively of potatoes and milk for months on end. Yet I lost faith in the method. A few failures, I suppose, put me off it. But I assure you, no deaths of fat glycosurics occurred. The patient who has no emaciation and no symptoms of bulimia or thirst I think is just as well left alone with a caution to be

sparing in the use of carbohydrates. It will fall to your lot pretty often to take over a patient whose life has been made fairly miserable by trying to dodge red meats, eggs and suchlike or sugar and starches in his food. You will be astonished to see how much more cheerful he is if he gets a less tyrannical order on this subject from yourself and is allowed to use them moderately. His spirits will improve and in general he will suffer no harm if you relax a little on this point.

Conclusion.

Do you wonder sometimes why men who profess and call themselves herbalists and other quack practitioners occasionally "wipe your eye?" You say to yourself: "He has never seen the inside of a human body; he knows nothing about anatomy, physiology or chemistry" and you cannot help knowing that occasionally your patients make greater progress under him than they did under you. At any rate you hear it, if you do not believe it.

This may interest you in relation to this condition of things. Years ago, finding that I had no appetite for breakfast (though I was living a very moral life and keeping no late hours, except those which were forced upon me by my professional calls) I determined to omit the ordinary breakfast. I breakfasted towards noon and had one other meal, dinner, at night. I was much better for it, much fitter for work. A friend noticing this peculiarity in my habits, told me that I was carrying out the treatment which had been advocated by a quack (whose name I will not mention for fear of advertising him!) in America. A little while afterwards in an American newspaper I saw an advertisement of a pamphlet written by this quack. I sent for it. He had four tenets which you will find worth thinking about:

1. Never eat when you are not hungry.

2. Never eat breakfast.

3. Chew every mouthful till its consistence is that of thick cream.

4. Separate the fluids and solids in your food from one another by one hour, drinking neither for an hour before your meal, at your meal, nor for an hour after.

I hope your patients will get as much good out of that advice as I and hundreds of my patients have had since I learned it. There is not much learning or science about it, but there are strong common sense and practical utility mixed up in it.

In relation to the insistence on no breakfast I would modify the advice given, perhaps, saying that whichever meal you find you have no appetite for would be missed with advantage, whether it be breakfast, lunch, dinner or supper or all three and I would add, avoid the cocktail before meals, especially if you have no appetite. A liqueur after dinner is worth two cocktails before it, because it stimulates digestion rather than appetite. There are pitfalls in the creating of artificial appetite.

Reviews.

FAUST UP-TO-DATE.

ON perusal "Outwitting Middle Age," by Dr. Carl Ramus, does not fulfil the promise of its pretentious title.[1] On its cover it is described as "a book which makes available to all laymen the vast advances of medical understanding of the causes and prevention of old age." Either the understanding of the causes or the understanding of the prevention has but a sorry claim to the eulogistic adjective, if this book be its star witness. And the layman's share of "perfect health and radiant youth" in perpetuity will be far to seek, unless he find some more subtle stratagem to outwit that crafty old practitioner, arteriosclerosis, than "a firm belief in the prevention of senility."

With the author it is an article of faith, but with us it is a matter of serious doubt whether all or any of the symptoms of middle age are to be ascribed to a mistaken belief, bred of frequent repetition, in the credibility of the psalmist's pessimistic estimate of man's expectation of life, as contained in the ninetieth Psalm at the tenth verse.

Further, any account of our human assets against our liabilities to time, heredity and environment which omits the item sound, sufficient and regular sleep, is doomed to be adjudged inadequate, however much emphasis be laid upon the advantages of vegetarianism, the allurements of exercise or the attractions of yogurt. The enthusiastic vegetarian, like the over-helpful witness, is prone to seek sanctuary in ambiguity. It may be quite true, as the author states, on page 177, that "proteid is abundantly supplied by beans, peas, lentils and nuts," but lacking the teeth of the horse, the crop of the bird and the digestive apparatus of the cow, man would be compelled to take too literally the slogan, "eat less and chew more," were he to attempt to derive his proteid ration from these succulent vegetables entirely. Besides rumination in company is an offence against the canons of social decorum.

In these days any book treating of the two themes which according to Dr. Ramus dominate civilized emotional life, "flaming youth" and rejuvenation, yet failing to mention the work of Voronoff and Steinach, falls inevitably under the same condemnation as salt which has lost its savour. To such an accusation "Outwitting Middle Age" justifiably pleads "not guilty," if the better parts of three chapters be accepted by the court as admissible exhibits. After reading the evidence the reader is forcibly reminded of the story of the advanced matronly person wheeling a very young looking male in a perambulator. Accosted by a croney who "didn't know she had one as young as that," she replied: "No, nor I 'aven't; it's me 'usbind; he went too far with this 'ere gland treatment."

Again it is hardly playing the game towards his old men and two ladies when they have served him as unique examples of longevity, to suggest that they would probably have done much better had they not fallen short through ignorance of his high ideals of meatless diet, of prohibitionist pleasures, of churchless Sundays and of leisure lacking tobacco.

One of Dr. Ramus's trump cards is a specific for ladies: "How to avoid the inconvenience of the climacteric." Doubtless our sisters will rejoice becomingly; but we trust for their sakes that it does not involve bearing a twenty-ninth child at sixty-eight years of age as happened to Mrs. Pedro Lorenzo.

A man, even a medical man, may be forgiven for the mistakes of others, but it is with his own pen that his death warrant is signed in the land of books. Our author in his introduction deposeth as follows: "the parts of this book for which some originality is claimed are found mostly in the chapters dealing with the psychology of ageing." Chapter VI, entitled "Subconscious Psychology" may appeal to the embryo materialist, but can only appal the variest tiro in psychology. Dr. Ramus states truly that: "one is hardly able to realise the bearing of subconscious complexes on the gradual development of senile

[1] "Outwitting Middle Age," by Carl Ramus, M.D.; 1926. London: George Allen and Unwin, Limited. Crown 8vo., pp. 280. Price: 7s. 6d. net.

changes in the human body." The dog in the street has never heard of King David and cannot therefore be impeded by any negative subconscious complex arising from that poetical monarch's faulty statistical statements, from attaining the age of Old Parr. Alas that such blissful ignorance should go unrewarded!

In paragraph "Consciousness and Force" Dr. Ramus is guilty of a glaring *petitio principii*, as the logicians say, to wit: "all forces are mutually convertible; that brings us to life. Life is obviously one of Nature's forces." Reasoning of this type naturally reaches the fatuous conclusion that consciousness is an emanation of life just as bile is a secretion of the liver.

But perhaps the happiest part of this rigmarole is the "Summary." "It is ruthless, self-centred and unmoral. Under discipline and harmony it is a splendid servant, when beyond control it is a demon of cruelty and destructiveness." There the reader has the matter in a nut shell. No, no, not a description of Bolshevism, but Dr. Ramus's account of the subconscious mind.

The spelling throughout the book is American, so only the over-bold in criticism would venture on pointing out misspellings; but "sane-sugar" on page 230 does not look quite right and "midle" on page 248 does not agree with the spelling on the cover.

Apart from these blemishes "Outwitting Middle Age" gives the layman as much hope of and help towards longevity as he is entitled to expect for seven shillings and sixpence. We, however, would prefer to invest the money in a dinner at the "Ambassadors" and to preserve an equal confidence of attaining our objective.

WOMEN AND EXERCISE.

"EXERCISES FOR WOMEN," by Ettie A. Hornibrook, is a little book of some forty-five pages.[1] It is well printed and the illustrations are good. The first twenty-eight pages are devoted to a spirited apologia for native dances, their beneficial effect in preventing constipation, prolapse and other ills to which women, especially civilized women, are heir.

The enthusiasm of the author is well shown in this section and her array of authorities on the subject is impressive; that she practises what she preaches is ovious from the illustrations.

The value of the exercises detailed in the latter part is undisputed and it is to be hoped they will be widely used; the fact that they are few in number and clearly described should make this possible.

IMMUNITY.

A new concept of immunity is presented by Besredka in the recently published work, "Local Immunization."[2] To explain his theories five type infections are used dealing with diseases of the skin and intestinal tract, namely infection with *Bacillus anthracis* staphylococcus and streptococcus (skin infections) and *Bacillus dysenteriæ* and the typhoid group (intestinal infections). After a brief historical review of the early attempts to solve the problem of anthrax infection the author quotes from an article published in 1921 in which he drew attention to the new facts observed. These were summarized under the headings, cuti-infection, cuti-vaccination and cuti-immunity. The experimental facts quoted then have since been confirmed and led to the following conclusions. The receptivity to anthrax infections resides principally if not wholly in the skin which has an affinity for the anthrax bacillus. Outside this the bacillus acts as a saprophyte. For example, a normal guinea pig is insensitive to anthrax infection when the virus is inoculated by any other method than into the skin. Immunization against the disease is produced by satisfying the "receptive" organs so that the cells of the skin then react in both processes—infection and immunity. The method of satisfying the receptive cells is by local application of vaccines on the shaven skin. Experiments show that with such local vaccination a protection against many times the lethal dose of the organism results, though there occurs no general immunity as evidenced by the formation of agglutinins or other specific antibodies. Further the serum of an animal locally immunized affords no protection to another animal. A local immunity can also be produced against staphylococci and streptococci which also have an elective affinity for the skin. The body responsible for the immunity is a thermostable atoxic substance present in the organism itself and recoverable from broth cultures by filtration. To this the name antivirus is given.

In admitting the possibility of an antitoxic factor in antidysentery immunity the author nevertheless believes that the seat of the refractory state is located mainly in the intestinal wall. This results in a local immunity with no antibody formation irrespective of whether the method of vaccination be subcutaneous, intravenous or buccal. In the case of typhoid infections the oral administration of bile with the vaccine is necessary to allow the receptive cells to become impregnated with the specific antigen. Here again a local immunity follows, though no antibodies can be demonstrated.

Besredka suggests that the receptive cells, specific in certain parts of the body for certain types of infections, act as local phagocytes. These receptive cells are really part of the reticulo-endothelial system. When the invading organism comes into contact with the cells for which it has an affinity, a reaction occurs and a substance is liberated—a product of secretion or disintegration of the bacteria. This upsets the leucocytes; phagocytosis by them does not occur and the organism thrives and multiplies.

When local vaccination has been effected, the receptive cells have lost their affinity and do not react with the invading organism so that no liberation of the repelling substance occurs and phagocytosis is not hindered. Vaccination then consists in desensitizing the special cells which are sensitive to a specific infection and is comparable to the desensitization which is used to remove an animal from the anaphylactic state.

The rôle of antibodies is of secondary importance—they follow the immunity, do not precede it. Besredka suggests that they may act as cytolysins of the protein stroma of the bacteria and result from the intracellular digestion of the stroma. In practising artificial vaccination the plan should be to follow the routes which the virus takes in its penetration of the body and so desensitize the receptive cells.

To those interested in immunity the book will offer much food for thought and interesting speculation. The reader will not fail to wonder what relation exists between Besredka's antivirus and d'Herelle's bacteriophage. Both these workers have rather startled the world of immunity with their views. Doubtless from these and similar researches will eventually come the elucidation of this vexed problem.

NURSES AND DRUGS.

"MATERIA MEDICA FOR NURSES" is a small book written by Professor A. Muir Crawford, of Saint Mungo's College, Glasgow.[1] The object of the book is that of presenting a short summary of the elements of *materia medica* which it is hoped may be helpful to members of the nursing profession, not only for examination purposes, but also as a handy book of reference after qualification. Only those drugs in common daily use have been considered with their important preparations, doses, actions and uses. No attempt has been made to present a complete list of drugs. This is a good book for the purpose for which it is written. It has the additional merit of not containing too much and for this reason as well as for the usefulness of its contents it is recommended to trainees and members of the nursing profession.

[1] "Exercises for Women: Being an Abbreviated Edition of Sex and Exercise," by Ettie A. Hornibrook; 1927. London: William Heinemann (Medical Books) Limited. Royal 8vo., pp. 55, with illustrations. Price: 3s. 6d. net.

[2] "Local Immunization, Specific Dressings," by Professor A. Besredka; Edited and Translated by Dr. Harry Plotz; 1927. Baltimore: The Williams and Wilkins Company. Royal 8vo., pp. 216. Price: $3.50 net.

[1] "Materia Medica for Nurses," by A. Muir Crawford, M.D., F.R.F.P.S.G.; 1927. London: H. K. Lewis and Company Limited. Crown 8vo., pp. 94. Price: 3s. 6d. net.

The Medical Journal of Australia

SATURDAY, DECEMBER 31, 1927.

Medical Politics.

THE annual meetings of the Victorian and Queensland Branches of the British Medical Association are held within a few days of each other. The attention of members is in consequence directed to those matters which concern the relationship of medical practitioners to their patients, to the community and to each other. The annual reports of two large Branch Councils usually cover the greater part of the field of medical politics. This year the two retiring Presidents have devoted their addresses to these matters. In the present issue Dr. H. V. Foxton's valedictory address will command the attention of members of the British Medical Association in all parts of Australia, even in regard to those subjects which have special reference to Queensland conditions. Dr. Foxton handles his matter with skill and does not hesitate to infuse into his messages views that may or may not find general acceptance throughout the whole of the Commonwealth. Dr. J. Newman Morris, whose address was published in our issue last week, sums up the subject of the relationship between the medical profession and the public in a manner that must appeal to everyone. He states that all the problems concern the efficiency of the work of the medical practitioner, the provision of medical service to the community and the very reason for the existence of the medical profession. Dr. Morris's words will be read with unusual care and attention because he has established as Chairman of Committees of the Victorian Branch the reputation of being a master of medical politics, one of the safest and soundest counsellors on all matters affecting the medical profession as a profession and a man of courage in facing new and difficult problems. These are the reasons that will stimulate members to read both these admirable addresses. Their contents will hold their interest and convince them of the wisdom of medico-political activity rather than of complacency and inertia.

Many members of the medical profession regard medical politics with disfavour. They are concerned with disease and its treatment. They hold that their obligations are restricted to their immediate duty to those persons who engage their services during periods of illness. Others are occupied with the scientific investigation of disease processes and imagine that as their work brings them in contact with persons suffering from disease only in an indirect manner, they have no concern with the problems dealt with in the annual reports of the Branch councils and in the addresses. These views are just as narrow and untenable as the outlook of the practitioner who evaluates medico-political activity by the effect it has on his income or that of the member of the medical profession who devotes all his energies to medico-political matters and neglects to keep his actual professional work in the most prominent place. Dr. Newman Morris reminds his readers that the profession is united in the British Medical Association for the purpose of exercising its influence to mould public opinion toward the establishment of means for the better carrying out of its work. The public distrusts combined effort and coordination, because this form of activity usually has for its object the financial benefit of the individual. If the changes that have been effected in the relationship between the medical profession and the community as a whole up to the present and those that will be introduced in the near future were not instruments for the improvement of the health of the people, they would be unsound and unacceptable. In the olden days the doctor treated his individual patient with a varying degree of success. He had no concern beyond treatment and it must be admitted that at times he was satisfied to apply treatment without having previously made even a working diagnosis. The care of the poor and of the large class of citizens of small means has entailed certain difficulties as modern methods of investigation and treatment have been introduced. With the advent of extreme specialism the problems in connexion

with public hospitals have brought about the need for adjustments. Matters are becoming still further complicated by the recognition of the duty of every member of the medical profession to take an active part in the prevention of disease. The medical profession must continue to give service to the public, but that service is gradually assuming an altered form and its value will be measured in a few years not by the results of treatment, but by the effect of each practitioner's efforts on the general standard of health.

If the Branches of the British Medical Association in Australia did not endeavour to formulate rules for the better performance of duties, for the maintenance of dignified and proper relations between medical practitioners calculated to enhance the value of the services rendered to the public and for the protection of medical practitioners against exploitation by individual members of the community and groups of individuals, the result would be chaotic and detrimental to the interests of the people of Australia. Hitherto the medico-political activities of the Branches have been measured and have been of a nature that commands the approval of each member. Intimidation and compulsion of the rank and file exerted by a small executive would be impossible, for the powers of the British Medical Association have been defined to exclude what is generally known as trades union methods. Moreover, medical practitioners would not long tolerate interference with their rights as practitioners and as citizens.

In the past doctors have often been sweated by friendly societies, other organizations and governments. At the present time there may be a tendency for the members of the Branches to drive collective bargaining a little too far, in order to insure equitable conditions of work. In the future the medical profession itself will exercise a control over the efficiency of the work of its members, in order that the value of the services rendered to the public may be of a high standard and commensurate with the remuneration for those services. The public will be educated to understand the essence of its relations to the medical profession and to impose a full measure of trust in that profession.

Current Comment.

PATHOLOGICAL CHANGES IN THE ISLANDS OF LANGERHANS.

THE common occurrence of pathological changes in the pancreas has left no doubt in the minds of scientific investigators that this gland and the variation in its function play the principal rôle in the production of the clinical entity known as *diabetes mellitus*. The observations of Allen and others on the effects of pancreatectomy in dogs shed light in many dark places, although it could not be recognized that the post-operative and clinical conditions were identical. The epoch making work of Banting and Best proved conclusively that the product of the islands of Langerhans, the pancreatic hormone, is the substance which controls carbohydrate metabolism. Sclerosis or degeneration of the islets results in a cutting off of the supply of hormone. The pathological process is a gradual one and it is obvious that a gland may be affected by histological changes of so slight a nature that clinical disability will not result. It is to be expected that study of glands of this type will yield valuable information and for this reason a recent article by A. W. Wright should receive careful attention.[1] Wright's study has been based on five cases encountered at Vanderbilt University Hospital during the routine performance of *post mortem* examinations. In the pancreas in each instance varying degrees of hyaline degeneration were found, but in none of the patients had the symptoms of *diabetes mellitus* been manifested during life and in only one instance was a trace of glucose found in the urine on one examination. All the patients were men over fifty years of age.

Hyaline degeneration of the islands of Langerhans was first described by Opie and subsequently by many other observers. In one of Opie's papers he described various degrees of involvement. Rare islands appeared to be uninjured. In others there were only a few small scattered masses of hyaline material here and there in the island closely associated with the capillary walls. When the lesion was most advanced, the island was practically replaced by hyaline homogeneous material in which a few elongated compressed pycnotic nuclei of parenchymal or endothelial cells remained. Wright points out that *diabetes mellitus* was present in all the cases reported by Opie and others and that it had usually existed for a long period, at least a year and often three or more. He holds that this type of degeneration characterizes a certain type of diabetes which is most commonly found after middle life. It may be present with or without a coexistent interacinar sclerosis, but is rarely found associated with an acute process. The insular changes found in younger individuals consist chiefly of inflammatory lesions in which leucocytic infiltration of the islands is present in the early stages and moderate to late sclerosis in the late stages. It may be well to point out that hyaline degeneration

[1] *The American Journal of Pathology*, September, 1927.

must not be confused with the hydropic degeneration described by Allen. These changes are characterized by a disappearance of the granules in the cells of the islands, a swelling of the cells with fluid and finally a disappearance of the island. They are the consequence and not the cause of the disease. Allen believes that this hydropic degeneration in dogs deprived of the pancreas is a specific diabetic phenomenon produced solely by overstrain of the function of the cells by diet in excess of the weakened assimilative power. This opens up the question of regeneration of island cells; reference will be made to that aspect later.

In discussing the changes observed, Wright points out that in three of the five cases no changes were observed in the acinar tissue; in the other two interacinar sclerosis was present. In the latter there was further evidence of a chronic inflammatory process as shown by a mild infiltration of the connective tissue septa with cells of the lymphocytic series. In two cases there was considerable hyaline thickening of the *tunica intima* of the smaller arteries, but this homogeneous material did not react to the stains as did the hyaline substance found in the islets. Wright concludes that the insular hyaline is not dependent, as far as can be determined, on the arteriosclerotic process. "The vascular changes appear to be merely coincidental and not in any sense causal." The hyaline material is laid down outside the blood vessel endothelium in the subjacent connective tissue. In all five cases there was evidence of hyalinization of many of the islands. The number of islands affected was always less than one-third of those studied. Hyaline masses were but rarely found outside the insular structures. In the islets which manifested the simplest type of involvement, only one or two small masses of hyaline were present. The islet cells were not abnormal except for slight pressure atrophy. When the insular involvement was more pronounced, the hyaline substance was seen to form a sort of cylinder ensheathing the vessel and the increasing pressure had caused atrophy of the parenchymal cells.

The question of the origin of the hyaline substance is an interesting one. There are three possibilities. Either it is the result of changes in the capillaries, that is, secondary to the arteriosclerotic process or it arises in the connective tissue as a result of some bacterial or metabolic poison or the connective tissue changes are in addition dependent in some way on the activities of the parenchymal cells of the islets. In all discussions on the work of Wright it must be remembered that he has presented only five cases and that the findings in these were not identical. The primary change in ordinary arteriosclerosis is in the *tunica media* and this is either productive or degenerative. In order to compensate for this change a reaction occurs in the intima with hyperplasia of the subendothelial connective tissue which undergoes hyaline, fatty and calcareous change. If the hyaline substance owed its origin to changes in the capillaries it would be expected that the acinar tissue of the pancreas would be affected equally with the islet tissue, but in three of Wright's five cases no changes were observed in the former. In the two in which this tissue was involved, there was, as already pointed out, further evidence of a chronic inflammatory process. The same objection holds in regard to the hypothesis that the hyaline material arises in the connective tissue. If some adjuvant action on the part of the parenchymal cells of the islets is postulated, it is possible to explain the findings. Here it is interesting to note that Opie regards the hyaline material as of epithelial origin and maintains that the degenerative process manifests itself first of all by changes in the protoplasm of the islet cells. Although Wright is opposed to the view of Opie and disagrees with his histological findings, it is impossible to deny to the islet cells some share in this process.

Wright's final conclusion is interesting. He holds that hyaline degeneration such as he has described, is responsible for only a small number of cases of *diabetes mellitus*. The cases which he has reported may be classed as belonging to a prediabetic group, sufficient insular tissue not being involved to bring about the clinical symptoms of *diabetes mellitus*. The hyaline material gradually accumulates, injures and finally destroys the insular tissue. Regeneration takes place, but the regenerated tissue is again slowly destroyed. The regenerative power of the pancreas is gradually worn down. This conclusion might presumably be applied to diabetes caused by a chronic inflammatory process as well as to that resulting from hyaline degeneration. The inflammation results in the formation of fibrous tissue and the cells of the islands are overcome by the gradually increasing pressure. In other words increase in intercellular fibrous tissue with lymphocytic infiltration in the early stages need not necessarily be accompanied by clinical diabetes. The phenomenon of regeneration is known to occur in many conditions. Even in acute yellow atrophy of the liver regeneration has been seen. The subject of regeneration in the pancreas has recently been investigated by G. R. Cameron.[1] Cameron removed portion of the pancreas of guinea pigs and then gave the animals injections of "Insulin" and pituitrin. He found that excision of part of the pancreas is in all probability followed by regeneration of acinar and islet tissue. His estimations were made quantitatively and while he was not able to prove regeneration with certainty, it was more than probable that it occurred. Regeneration was inhibited by both "Insulin" and pituitrin. This may be explained by the view that the "Insulin" supplied the hormone which would have been supplied by the portion of the gland which had been removed. It also suggests that there is a relationship between the pituitary gland and the pancreas. This supposition is strengthened by Cameron's finding that both "Insulin" and pituitrin caused hypertrophy of the pancreas of control animals and that pituitrin produced an increase in the relative amount of islets. It must be remembered that Wright found regeneration in both unaffected and affected islets and the question may therefore be asked as to whether the pituitary gland plays any part in the phenomena described by him.

[1] *The Journal of Pathology and Bacteriology*, October, 1927.

British Medical Association News.

ANNUAL MEETING.

THE ANNUAL MEETING OF THE QUEENSLAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION was held at the B.M.A. Rooms, Adelaide Street, Brisbane, on December 9, 1927, DR. H. V. FOXTON, the President, in the chair.

Annual Report of the Council.

The annual report of the Council for 1927 was taken as read, received and adopted on the motion of DR. H. V. FOXTON, seconded by DR. F. A. HOPE MICHÔD.

THE Council has pleasure in presenting the following report of the work of the Branch for the year ended November 15, 1927.

Membership.

The membership of the Branch which was 428 at the end of last year, has increased to 450. The additions have been: Elections of new members 19, transferred from other Branches 34, reinstated 4. The losses have been: Transferred to other Branches 24, unfinancial 4, resigned 3, deaths 5.

The Council regrets to record the deaths of the following members: Dr. R. F. Bower, Dr. J. Booth Clarkson, Dr. Andrew Stewart, the Honourable Dr. W. F. Taylor, Dr. P. L. Townley.

Meetings.

General.

Ten ordinary general meetings were held during the year which included one clinical meeting at the Brisbane Hospital and one clinical meeting at the Mater Misericordiæ Hospital, a combined meeting with the Institution of Engineers, a Lister Centenary Memorial Meeting, a meeting at Townsville and a Bancroft Memorial Lecture. The average attendance was 38·5.

Five extraordinary meetings were held as follows: Formation of a surgical section, hospital policy, members holding lodge appointments (2) re premises and formation of an obstetrical section. The average attendance was 32·5.

Council.

The Council held eighteen meetings. The record of attendance of members of the Council was as follows:

	Attendance.	Apologies.
DR. H. V. FOXTON[1] (President)	17	1
DR. EUSTACE RUSSELL[2] (President Elect)	17	1
DR. E. SANDFORD JACKSON[3] (Vice-President)	12	5
DR. E. S. MEYERS (Honorary Secretary)	18	—
DR. F. A. HOPE MICHÔD (Honorary Treasurer and Chairman of Committees)	16	2
DR. NEVILLE G. SUTTON (Honorary Librarian)	15	2
DR. M. GRAHAM SUTTON (Honorary Curator of Museum)	15	1
DR. W. N. ROBERTSON[4] (Federal Committee representative)	6	10
DR. D. GIFFORD CROLL[5] (Federal Committee representative)	14	—
DR. A. G. ANDERSON (Councillor)	9	—

[1] Attending meeting held at Townsville.
[2] Attending meeting Toowoomba.
[3] Attending meeting Toowoomba.
[4] Apologies due to attending Australasian Medical Congress and illness.
[5] Appointed March 11, one apology due to attending Australasian Medical Congress.

	Attendance.	Apologies.
DR. G. P. DIXON[1] (Councillor)	10	4
DR. A. H. MARKS (Councillor)	14	3
DR. A. P. MURPHY[2] (Councillor)	14	4
DR. S. F. MCDONALD (Councillor)	16	—
DR. VAL. MCDOWALL[3] (Councillor)	13	5
DR. H. W. TILLING (Councillor)	17	1
DR. MERVYN S. PATTERSON (Councillor)	9	2
DR. J. LOCKHART GIBSON[4] (Councillor)	1	—

Chairman of Committees.

In April, Dr. F. A. Hope Michôd was appointed Chairman of Committees.

Papers.

The following papers were read during the year:

February 4.—Clinical Meeting, Brisbane Hospital.
March 4.—Combined meeting with Institution of Engineers—"Technical Science in Relation to General and Preventive Medicine."—MR. J. S. JUST, M.I.E. Aust., M.I.E.E., M.Am.I.E.E.
April 5.—Lister Centenary Commemoration—Oration delivered by DR. J. LOCKHART GIBSON.
May 6.—"A Review of Some Recent Work on Goître."—DR. D. GIFFORD CROLL.
June 3.—"Silicosis," illustrated by X ray films.—DR. T. GORDON ROSS. Held at Townsville.
July 1.—"Diathermy in General Practice."—DR. A. J. REYE.
August 5.—Bancroft Memorial Lecture—"Puerperal and Post Abortion Sepsis."—PROFESSOR J .C. WINDEYER, Sydney.
September 2.—Clinical Meeting, Mater Misericordiæ Hospital. Subject: "Pyelitis."
October 7.—"Mental Healing."—DR. JOHN BOSTOCK.
November 4.—"Notes on Diet."—DR. E. SANDFORD JACKSON.

The members of the subcommittee responsible for the programme of papers were DR. EUSTACE RUSSELL, DR. F. A. HOPE MICHÔD and DR. A. P. MURPHY.

Many interesting cases and specimens were exhibited at the various meetings.

The interest of the meetings has been greatly increased by the purchase of a Balopticon, the cost of which was shared by the Branch and the post-graduate subcommittee.

Representation.

The Branch was represented as follows:

Council of British Medical Association.—MR. T. P. DUNHILL.

Representative Body.—DR. E. A. FALKNER.

Federal Committee of the British Medical Association in Australia.—DR. W. N. ROBERTSON and DR. D. GIFFORD CROLL.

Australasian Medical Publishing Company, Limited.—DR. W. N. ROBERTSON (Chairman), SIR DAVID HARDIE, M.D., and DR. J. LOCKHART GIBSON (members).

Bush Nursing Association.—DR. N. W. MARKWELL.

Advisory Council of Industrial Welfare.—DR. E. S. JACKSON and DR. H. W. TILLING.

Cancer Committee.—DR. E. S. JACKSON, DR. VAL. MCDOWALL, DR. E. D. AHERN, DR. H. W. TILLING, DR. J. B. MCLEAN, DR. A. T. NISBET, DR. E. S. MEYERS.

Museum.

The specimens are now housed in the Pathological Museum attached to the Hospital for Sick Children, Brisbane, where members may inspect them.

Library.

There have been no additions to the library (beyond the periodicals to which we subscribe) except by donation as follows: Mrs. R. A. Macleod, old issues of *The British Medical Journal* and *The Lancet;* Mr. G. H. Barker,

[1] On leave two meetings.
[2] On leave two meetings.
[3] On leave two meetings.
[4] Resigned on January 28, 1927.

Cumston's "Medical History"; Dr. A. Jefferis Turner, a number of miscellaneous medical books.

On behalf of the Branch we wish to express our thanks to the donors for their respective gifts.

The Honorary Librarian has been empowered to make a collection of duplicate books in the library for distribution to the Downs and South Western Medical Association and the West Moreton Medical Association.

Affiliated Local Associations.

The following is a list of the Local Medical Associations which have been formed during the year:

Downs and South Western (Toowoomba), Honorary Secretary: Dr. A. J. Spencer Roberts; Representative on Council: Dr. Eustace Russell.

West Moreton Medical Association (Ipswich), Honorary Secretary: Dr. G. H. Brandis; Representative on Council: Dr. M. S. Patterson.

Maryborough, Honorary Secretary (*pro tempore*): Dr. W. Gillbee Brown; Representative on Council: Dr. G. P. Dixon.

Bundaberg, Honorary Secretary: Dr. Egmont Schmidt; Representative on Council: Dr. A. P. Murphy.

Cairns, Honorary Secretary: Dr. P. S. Clarke; Representative on Council: Dr. S. F. McDonald.

Townsville, Honorary Secretary (acting): Dr. A. H. Baldwin; Representative on Council: Dr. Neville G. Sutton.

Central Western Local Medical Association, Honorary Secretary: Dr. C. V. Watson Brown; Representative on Council: Dr. F. A. Hope Michôd, Longreach.

Western Medical Association, Honorary Secretary: Dr. A. W. Fox, Charleville; Representative on Council: Dr. A. G. Anderson.

Rockhampton, Honorary Secretary: Dr. J. Bruce Gordon; Representative on Council, Dr. E. S. Meyers.

Townsville.

A general meeting of the Branch was held at Townsville on June 3, at which there was an attendance of twenty members, including representatives of other northern towns. The President and Dr. A. Jefferis Turner represented the metropolitan members.

Toowoomba—"Group System."

At the request of the Downs and South Western Medical Association Dr. E. S. Jackson and Dr. Eustace Russell visited Toowoomba to represent the Council at a round table conference between members of the Toowoomba Hospital Board and representatives of the local medical association to discuss the question of rural and industrial groups connected with the Toowoomba Hospital, over which there has been a good deal of controversy. A very satisfactory discussion took place.

We have subsequently been notified that the following developments have occurred:

1. Both rural and industrial groups are to continue.
2. Members to be eligible for membership of the groups must not be in receipt of income exceeding £250 for single men and £300 for married men.
3. No member of any group can be admitted to the hospital (except emergency cases) unless he has a letter of admission from a medical practitioner.
4. An admission officer has been appointed to make the necessary inquiries as to the financial standing of every person admitted to the hospital, including members of groups. Members of the honorary staff can secure such information from the admission officer if he requires it.

Federal Committee.

Two meetings of the Federal Committee of the British Medical Association in Australia were held during the year, the Branch being represented by Dr. W. N. Robertson and Dr. D. Gifford Croll. Owing to illness Dr. Robertson was unable to attend the meeting held in Sydney in September and Dr. Croll represented the Branch. Reports of the proceedings will be found in THE MEDICAL JOURNAL OF AUSTRALIA of April 14, 1927, and October 22, 1927.

Australasian Medical Congress (British Medical Association).

The Second Session of the Australasian Medical Congress (British Medical Association) was held at Dunedin, New Zealand, from February 3 to 10. Owing to distance very few members of the Branch were able to attend and only eighteen joined the membership list.

Australasian Medical Publishing Company, Limited.

Journal.

In February, 1926, the Directors of the Company passed a resolution to the effect that the Branches be asked to support a proposal that the journal be increased in size to a minimum of forty pages and that they pay 30s. instead of 20s. per member *per annum*. A referendum of members of the Branch was taken on this question which resulted in an affirmative vote by a small majority. No further steps were taken by the Company, however, because it was found that the additional revenue from advertisements was assisting, to some extent, in allowing the size of the journal to be increased which, during the first half of 1927 contained thirty-six pages as against an average of twenty-eight in the 1926 issues. The Directors now feel that they should look to the Branches for assistance to keep up the size of the journal without loss of profit. Under the circumstances they have been reluctantly compelled to increase the charge to the Branches from 20s. to 25s. *per annum* per member, an increase from 4⅗d. to 5¾d. per copy including postage. This increase will take effect from January 1, 1928. The Directors believe that the increase will only be necessary for about five years.

The Branch will, therefore, require to increase the membership subscription to meet the additional cost for the journal.

Debentures.—In July last two debentures of £25 each were purchased for the Branch in the above mentioned Company.

Hospital Subcommittee.

Personnel: DR. E. S. JACKSON, DR. A. H. MARKS, DR. VAL. MCDOWALL, DR. G. P. DIXON (convener). Nine meetings were held during the year.

Hospital Policy.

The hospital question is gradually becoming more satisfactory and as a result of the cooperation of the Home Secretary draft rules, in accordance to a large extent with the hospital policy of the branch, have been issued to country hospital boards and committees. Several clauses were not approved of by the Branch, notably one which endeavoured to make the doctor responsible for the hospital fees of private ward patients, which was strongly opposed by the Council. The whole question is being reconsidered by the Home Secretary. A copy of the draft rules was published in THE MEDICAL JOURNAL OF AUSTRALIA of June 23, 1927, for the information of members and comment was invited thereon, which resulted in a response indicating general satisfaction on the whole. In this connexion the following ruling of the Home Secretary is important:

> Every medical practitioner, including the medical officer, shall be entitled to have his patients admitted to the private wards or otherwise accommodated as private patients, provided accommodation is available.

A conference of representatives of country local medical associations was held in March, when the hospital policy of the Branches was accepted without amendment. Dr. T. P. Connolly, of Toowoomba, was the only country delegate present, the other associations being represented by their Council representative with whom they had been in touch on the matter by correspondence. A conference was also held with the Council of the Bush Nursing Association, Queensland, regarding the hospital policy, when it was agreed that they would work under the direction and in conformity with the principles of the Queensland Branch of the British Medical Association.

Hospital Conference.

At the request of the Council the Brisbane and South Coast Hospitals Board arranged a conference of interested bodies which was held on September 28. The following bodies were represented in addition to the Branch: Brisbane and South Coast Hospitals Board, University, Greater Brisbane Council, Ambulance Brigade, public press and large private hospitals. The Branch was represented by the subcommittee and Dr. E. S. Jackson and Dr. C. E. Tucker were amongst the speakers.

A resolution was unanimously carried as follows:

> That the Home Secertary be asked to appoint a technical advisory board, consisting of one representative chosen by the Home Secretary's office, one chosen by the University, one chosen by the City Planners' Department of the City Council, one chosen by members of the medical profession and one architect chosen by the Institute of Architects to act as a direct advisory board to the Home Secretary on all matters relating to the needs of the community so far as hospital facilities are concerned for the present and the future and to select qualified architects to develop plans for such institutions, as well as to advise on other matters appertaining to the service of the sick.

No further action has since been taken in this matter.

Brisbane and South Coast Hospital Board—Fees for Work Done at the Pathological and Anatomy Departments.

A meeting of the Hospital Subcommittee with members of the Brisbane and South Coast Hospitals Board and the Brisbane Hospital Advisory Committee was held in August at the request of the Council. It was resolved at the meeting:

> That the work in the laboratory of the Brisbane and South Coast Hospitals Board should be carried out only for people who cannot afford to pay full fees; those able to pay full fees to be directed to seek the services of a private bacteriologist.

It was also mutually agreed that the fees chargeable for patients within the above should be 60% of the fees set out in the schedule of fees drawn up by the Board.

Anatomy fees: The amount fixed was £2 2s. per part.

Many individual cases on behalf of country members were dealt with by the subcommittee.

Lodge Subcommittee.

Personnel.—Council Subcommittee: Dr. A. G. Anderson and Dr. M. Graham Sutton (convener); special subcommittee appointed to deal with the model lodge agreement: Dr. G. H. Brandis, Dr. A. B. Carvosso, Dr. D. Gifford Croll, Dr. F. G. Meade, Dr. G. A. Sampson, Dr. M. Graham Sutton, Dr. C. E. Tucker; Coopted: Dr. J. L. Selwood, Dr. Ellis Murphy, Dr. D. V. Sheil, Dr. A. B. Stark, Dr. L. W. Gall and Dr. Kenneth Wilson.

The outstanding features of the present year have been:

1. *Federal Model Lodge Agreement—Adoption by Federal Committee.* Dr. E. S. Meyers and Dr. M. Graham Sutton represented the Branch at the interstate conference of lodge delegates (British Medical Association) which was held in Melbourne on April 26 prior to the meeting of the Federal Committee. A full account of the decisions arrived at by the Federal Committee will be found in The Medical Journal of Australia of May 14, 1927.

The matter is still under consideration by the Branch.

2. *Provision of Hospital Facilities for Lodge Members.* It will be remembered that this matter was brought up by the Friendly Societies Medical and Hospital Council and the Special Lodge Subcommittee is still carrying on negotiations with this body.

Public Health Subcommittee.

Personnel.—Dr. S. F. McDonald, Dr. A. G. Anderson and Dr. H. W. Tilling (convener).

The activities of the subcommittee included:

1. A suggested scheme for the prevention of tuberculosis which was submitted to the Federal Committee and has been referred back for further elaboration.

2. They were also associated with the Institute of Engineers regarding the formation of the Advisory Council of Industrial Welfare, which is referred to in another part of this report.

3. Water Conservation Scheme.—Dr. Tilling was appointed to represent the Branch at a meeting of scientific bodies organized by the Australian Chemical Institute.

4. The matter of subjects to be placed before the Royal Commission on the constitution of the Commonwealth to be held in September, 1928, is at present under consideration.

Maternal Mortality and Morbidity.

Personnel.—Dr. D. Gifford Croll and Dr. A. H. Marks. Dr. A. Jefferis Turner and Dr. H. W. Tilling were coopted.

A report drawn up by Dr. Croll on behalf of the subcommittee was submitted to the Council, which contained a proposal that a medical man be appointed Director of Obstetrical Research on the same lines as the Victorian scheme and that the Home Secretary and the Red Cross Committee be approached in this connexion.

At the suggestion of the subcommittee an obstetrical section has been formed.

Premises.

Personnel.—Dr. H. V. Foxton, Dr. F. A. Hope Michôd and Dr. E. S. Meyers.

This subcommittee was appointed at the annual meeting held on December 10, 1926.

Meetings were held in conjunction with the Directors of the Queensland Medical Land Investment Company, Limited and Ballow Chambers, Limited. The Managing Director of the former company (Dr. W. N. Robertson) stated that the company was formed to provide accommodation for the Branch until such time as it was able to hold property and take over the building. Also that the Directors are now prepared to hand over the property to the Branch when it assumes responsibility for debentures and the mortgage to the Diocesan Council of the Church of England. Several propositions have been placed before the Council through the subcommittee and a special meeting of the Branch was held on November 9 to consider the matter. It was decided to take steps to move the location of the Branch and the question of finance and a suitable site is under consideration.

New Rules of the Branch.

The issue of the new Rules and By-laws has been delayed pending finality being reached regarding intra-professional restrictions, but it is hoped that they will be in the hands of members before long.

Post-Graduate Course.

A very successful course was held from August 1 to 5. The programme included a practical demonstration of "Methods of Abdominal Palpation" by Professor J. C. Windeyer (Sydney) and three lectures by Dr. F. L. Apperly (Melbourne) on "Modern Views on Gastric Function in Health and Disease."

There was a membership of sixty, but it was disappointing that more country members did not join.

It has been decided that at next year's course:

(i) All morning work will be abolished;

(ii) That the clinical work and hospital demonstrations will be arranged in the afternoons at the hospitals;

(iii) The main lectures will be held at night in the B.M.A. Building.

Permanent Honorary Secretaries: Dr. S. F. McDonald and Dr. Neville G. Sutton have been appointed and have been asked to draw up a scheme to provide facilities for post-graduate work for country members, such facilities to be available throughout the year.

The Brisbane Hospital and the Mater Misericordiæ Hospital authorities have kindly promised to supply daily

lists of operations and times of visiting of the honorary staffs which are posted on the notice board in the B.M.A. room.

Bancroft Memorial Lecture.

The lecturer for this year was Professor J. C. Windeyer, Sydney, the title of his paper being: "Puerperal and Post-Abortion Sepsis." The thanks of the Branch are due to Professor Windeyer for his interesting lecture.

Photographs of Past Presidents.

Photographs of past presidents of the Queensland Branch of the British Medical Association and of the former medical societies are being collected for the Branch. So far we have twenty-one photographs, but there are still a few outstanding, which the Council would be glad to receive to complete the set.

Normal and Morbid Anatomy Department.

In connexion with the teaching of dental students at the Brisbane Dental Hospital, a school of anatomy has been established and arrangements were made by the Joint Board of Dental Studies whereby medical men were given facilities for carrying out anatomical work. At present sixteen medical men are making use of the facilities.

QUEENSLAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION (INCORPORATED).

Statement of Receipts and Payments for Twelve Months Ended November 15, 1927.

RECEIPTS.

	£	s.	d.	£	s.	d.
November 16, 1926.						
To Cash at Banks and in Hand—						
Credit Balance, National Bank of Australasia, Limited, Brisbane	81	8	7			
Credit Balance, Commonwealth Savings Bank, Brisbane	278	3	2			
Cash in Hand	2	2	4			
				361	14	1
November 15, 1927.						
„ Subscriptions—						
British Medical Association, London	550	18	3			
THE MEDICAL JOURNAL OF AUSTRALIA	442	0	0			
Queensland Branch Subscriptions	236	18	9			
Organization Fund, Queensland Branch	496	0	0			
				1,725	17	0
„ Dividends and Interest—						
Queensland Medical Land Investment Co., Ltd.—Dividend 6% on 1,235 shares paid to 10s. each	37	1	0			
Commonwealth Savings Bank—Interest on Current Account to June 30, 1927	10	7	6			
				47	8	6
„ British Medical Association, London—Capitation Grant ..				0	6	0
„ Rebates on Amounts Remitted to London				0	18	10
„ Subscriptions to Dinner in Honour of His Excellency Sir John Goodwin				151	10	0
„ Subscriptions to Annual Dinner				56	14	0
Forward				£2,344	8	5

PAYMENTS.

	£	s.	d.	£	s.	d.
November 15, 1927.						
By British Medical Association, London—						
Remittances on account of Subscriptions 1926 and 1927—						
Balance due to November 15, 1926	26	2	9			
On account of Subscriptions collected 1927 ..	513	6	0			
				539	8	9
„ Australasian Medical Publishing Company, Limited—						
Remittances on account of Payments for THE MEDICAL JOURNAL OF AUSTRALIA—						
Balance due to November 15, 1926	17	10	0			
On account of Payments in 1927	416	10	0			
				434	0	0
„ Library Expenditure—						
Books, Journals and Bookbinding				34	11	7
„ Branch Expenses—						
Secretary Salary	266	18	4			
Assistant Secretary, Salary Two Weeks, Nov., 1927 ..	3	10	0			
Printing and Stationery ..	54	9	1			
Electric Light	14	5	2			
Bank Charges .. £7 2 1 *Less* Exchanges Refunded .. 6 5 3	0	16	10			
Postage and Duty Stamps and Telegrams	42	19	3			
Rent Dec. 1, 1926, to Nov. 30, 1927	52	0	0			
Cleaning	42	13	3			
Telephone	19	8	2			
Audit and Preparation of Special Statements to Nov. 15, 1926	16	16	0			
General Expenses	41	13	5			
Expenses Federal Committee and Lodge Conference ..	75	10	0			
Federal Committee Constitution Expenses	43	14	0			
Insurance, Fire and Workers' Compensation	2	15	6			
Legal Costs	6	6	0			
Reporter, Hospital Conference	5	0	0			
Architect's Fees re proposed new building, Boundary Street	10	10	0			
Advice re taxation on proposed Sale of B.M.A. Building	3	3	0			
Subscription to Far Eastern Medical Congress, 1927 ..	2	0	0			
Subscription, Town Planning Association	2	2	0			
				706	10	0
Forward				£1,714	10	4

STATEMENT OF RECEIPTS AND PAYMENTS—*Continued.*

RECEIPTS—*Continued.*

	£ s. d.	£ s. d.
Forward		£2,344 8 5
		£2,344 8 5

PAYMENTS—*Continued.*

	£ s. d.	£ s. d.
Forward		£1,714 10 4
„ Dinner in Honour of His Excellency Sir John Goodwin		144 14 1
„ Annual Dinner Expenditure ..		41 11 0
„ Australasian Medical Publishing Company, Limited, Sydney—		
Two Debentures of £25 each		50 0 0
„ Queensland Medical Land Investment Company, Limited—		
50 Shares of £1 each paid to 10s. each		25 0 0
„ Furniture and Fittings—		
One Addressing Machine ..	15 0 0	
Typewriter £25 16 0		
Less Refund by Aust. Trained Nurses Association 3 0 0		
	22 16 0	
One-third of Cost of One Balopticon Lantern (two-thirds cost paid from Post-Graduate Course Fund)	17 18 4	55 14 4
„ Cash at Banks and in Hand—		
Credit Balance, Commonwealth Savings Bank, Brisbane	325 11 8	
Cash in Hand	3 8 11	
Less Debit Balance, National Bank of Australasia, Ltd., Brisbane	16 1 11	
		312 18 8
		£2,344 8 5

QUEENSLAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION (INCORPORATED).

Balance Sheet as at November 15, 1927.

LIABILITIES.

	£ s. d.	£ s. d.
Accumulation Fund—		
Balance on November 16, 1926	1,210 11 4	
Add Balance Transferred from Revenue Account at November 15, 1927	46 15 1	
		1,257 6 5
British Medical Association, London		
Balance at November 16, 1926	26 2 9	
Subscriptions collected to November 15, 1927	550 18 3	
Less Remittances to London	539 8 9	
		37 12 3
Australasian Medical Publishing Company, Limited, Sydney—		
Balance at November 16, 1926	17 10 0	
Subscriptions collected to November 15, 1927	442 0 0	
Less Remittances to Sydney	434 0 0	
		25 10 0
National Bank of Australasia, Limited, Brisbane—		
Debit Balance, Current Account		16 1 11
		£1,336 10 7

ASSETS.

	£ s. d.	£ s. d.
B.M.A. Rooms, Adelaide Street—		
Library	150 0 0	
Book Cases	25 0 0	
Furniture and Fittings, Lantern, Typewriters, etc.	120 0 0	
Museum Specimens	20 0 0	
		315 0 0
Queensland Medical Land Investment Company, Limited—		
1,285 Shares paid to 10s. each		642 10 0
Australasian Medical Publishing Company, Limited, Sydney—		
Two Debentures of £25 each ..		50 0 0
Cash at Banks and in Hand—		
Credit Balance, Commonwealth Savings Bank, Brisbane ..	325 11 8	
Cash in Hand	3 8 11	
		329 0 7
		£1,336 10 7

Audited and found correct.

ROY G. GROOM,
Fellow of the Australasian Corporation of Public Accountants.
Auditor.

Brisbane, November 21, 1927.

F. A. HOPE MICHÔD,
Honorary Treasurer.

Public Health.

The Branch has been working in close cooperation with the City Medical Officer of Health, Dr. H. W. Tilling, throughout the year. In this connexion a diphtheria immunization scheme will shortly be launched in Brisbane.

National (Medical) Insurance.

Subcommittee: Same personnel as Special Lodge Subcommittee.

A proposed scheme was drawn up and submitted to the Council which was subsequently forwarded on to the Federal Committee. The proposals were very similar to those submitted by the Victorian Branch. A meeting of this subcommittee will shortly be held to consider the resolution passed by the Federal Committee in relation thereto. In July a meeting of members of the Council and the subcommittee was held to discuss the matter with Senator Millen, Chairman of the Advisory Committee on National Insurance. It was learnt that the present scheme does not include health insurance necessitating medical treatment; the services of the medical profession would be required for certification only. Senator Millen mentioned that it was recognized how essential it was for the success of the scheme to have the cooperation of the British Medical Association, as certificates would be required for "going on" and "coming off." He also drew attention to the fact that medical men will, it is anticipated, be dealing largely with their own patients. He stated that medical referees would be appointed and the State would be divided into districts.

The national insurance bill has not yet been submitted to Parliament. The question is closely watched by the Branches in the interests of the medical profession.

Cancer Campaign.

At the instigation of Sir Neville Howse a public meeting regarding a cancer control campaign was held on August 26, 1927. The representatives of the medical profession appointed included the President (Dr. H. V. Foxton), Dr. E. S. Jackson, Dr. Val. McDowall, Dr. E. D. Ahern, Dr. H. W. Tilling, Dr. J. B. McLean, Dr. A. T. Nisbet and Dr. E. S. Meyers. His Excellency Sir John Goodwin who was a member of the Cancer Committee in England, is keenly interested in the movement.

The matter is still in its initial stage.

Advisory Council of Industrial Welfare.

This Council has been formed as a result of a resolution passed at the combined meetings of members of the Branch and the Institution of Engineers, Australia, as follows:

> That in the opinion of this meeting a body of not more than twelve members be formed, consisting of representatives of the British Medical Association (Queensland Branch) and scientific and commercial bodies, together with a representative of the Trade Labour Council and of the Government for the purpose of discussion and advising on health matters of communal importance and those more particularly relating to industrial medicine and hygiene.

Dr. E. S. Jackson and Dr. Tilling have been appointed to represent the Branch on this Council.

Trustees of the Branch.

In consequence of the death of the Honourable W. F. Taylor, M.D., who was one of the Trustees of the Branch for many years, Dr. F. A. Hope Michôd was appointed to take his place. Dr. W. N. Robertson and Dr. J. Lockhart Gibson are the other trustees of the Branch.

Sections for Special Branches of Medical Knowledge.

Eye, Ear, Nose and Throat Section.

Chairman: Dr. J. Lockhart Gibson; Honorary Secretary: Dr. Walter Lockhart Gibson. Membership 14.

The section has held three meetings during the year which have been well attended. A number of interesting cases were shown on each occasion and members entered freely into the discussions.

Dr. Arthur Murphy resigned from the position of Honorary Secretary and Dr. Walter Lockhart Gibson was appointed to the position.

Surgical Section.

Chairman: Dr. E. Sandford Jackson; Honorary Secretary and Treasurer: Dr. Milton Geaney. Membership 28.

Two meetings have been held since the formation of the section in March.

Obstetrical Section.

This section is at present in process of formation, an inaugural meeting having been held on November 15.

Sir John Goodwin, K.C.B., C.M.G., D.S.O., F.R.C.S. (Eng.), D.Sc.

The Branch is honoured by the membership of Sir John Goodwin who took up his position as Governor of Queensland during the year. A welcome was extended to his Excellency shortly after his arrival which took the form of a dinner held at Rowe's Banquet Hall. The members greatly appreciated the presence of his Excellency who appeared to enjoy the function. There was a large and representative attendance of members.

Social.

The Branch held its usual annual dinner on August 3, 1927, at the Belle Vue Hotel, at which fifty-three members were present. Professor J. C. Windeyer, Dr. F. L. Apperly and Dr. Cooper Pattin (Norwich, England) were the guests of honour.

The Post-Graduate Committee also arranged a dance at the National Hotel on the opening night of the course, which was voted a most enjoyable evening by those present.

Gifts.

The Branch is indebted to Dr. J. Lockhart Gibson for a very fine portrait of Lister, handsomely framed; also to Dr. D. Gifford Croll who presented the Branch with twenty shares in The Queensland Medical Land Investment Company, Limited.

Ethical.

Members are notified that it has been decided by the Council, that before consenting to deliver a public address on any medical subject, they must obtain the permission of the Council.

Conclusion.

In conclusion it may be stated that the year has been an onerous one for members of the Council. Seldom, if ever before, have such a number of important matters had to be dealt with in any one year and the members of the various subcommittees have found their hands very full.

A most important departure in the history of the Branch has been the formation of the local medical associations, each being represented on the Council by a member of the Council. These local associations tend towards professional unity outside the metropolis and are also of great value in settling disputes and adjusting difficulties by men who are thoroughly in touch with local conditions.

A pleasing aspect of the year has been the rarity of disputes between members of the Branch and it can be affirmed safely that on the whole the standard of medical ethics in this State is a high one and the good feeling between members very commendable.

Election of Office Bearers.

The President declared the result of the ballot for the election of office bearers and members of the Council as follows:

President: Dr. Eustace Russell.
President-Elect: Dr. Mervyn S. Patterson.
Vice-President: Dr. H. V. Foxton.

Members of Council: Dr. D. G. Croll, C.B.E., Dr. E. Sandford Jackson, Dr. C. M. Lilley, Dr. E. S. Meyers, Dr. F. A. Hope Michôd, Dr. A. P. Murphy, Dr. L. J. Nye, Dr. W. N. Robertson, C.B.E., Dr. H. V. Tilling, Dr. D. E. Trumpy, Dr. A. J. McDonald, Dr. Val McDowall, Dr. M. Graham Sutton and Dr. Neville G. Sutton.

B.M.A. Building.

DR. W. N. ROBERTSON, on behalf of the Medical Land Investment Company, informed the meeting that at a recent meeting of that company the following resolution had been passed:

> That the Queensland Branch of the British Medical Association be asked to take over the B.M.A. Building forthwith.

President's Address.

DR. H. V. FOXTON, the retiring President, delivered an address (see page 902).

Induction of President.

DR. H. V. FOXTON asked Dr. Eustace Russell, the newly-elected President, to take the chair which he was vacating. He wished Dr. Russell a very happy and prosperous year as President of the Queensland Branch of the British Medical Association.

DR. EUSTACE RUSSELL said he was eager to thank the members of the Branch for the great honour conferred on him and the compliment paid him by his appointment to the presidential chair—an honour and compliment which he fully appreciated. He was cognizant of the duties and obligations imposed by appointment to such an office and hoped he would be worthy of the position in which they had placed him. After working for the past year beside Dr. H. V. Foxton, he felt sure that it would be very difficult for him to achieve what his predecessor had achieved and to come up to the high standard set by him. He was very glad to know that Dr. Mervyn Patterson had been selected by the Branch as President-Elect and he was happy and fortunate to have such a good team of Councillors to work with in 1928. He then referred more particularly to the important work on hospital policy, cancer control *et cetera* which lay before the Council of 1928 and which he hoped he and they would be able to carry out to the full satisfaction of the Branch.

DR. E. S. JACKSON moved a hearty vote of thanks to Dr. H. V. Foxton for his excellent presidential address. The address, he said, had been characterized by a fine candour and outspokenness and he (Dr. Jackson) stated that he had never before heard an address with which he was so much in accord and sympathy. He agreed entirely with all Dr. Foxton had so well said.

DR. J. LOCKHART GIBSON, in seconding the vote of thanks, expressed his appreciation of Dr. Foxton's most interesting and thoughtful address. He desired also to congratulate him warmly on his very satisfactory and successful year of office as President of the Branch.

The vote of thanks to Dr. Foxton was carried by acclamation.

Subscription to the Branch.

DR. EUSTACE RUSSELL, the President, then informed the meeting that there was a recommendation from the Council to the Branch to the effect that the existing subscription rates be increased. Although the matter was to be left over for settlement to the next general meeting of the Branch, he invited immediate discussion on the point by members present.

A discussion then ensued as to the advisability of increasing the present subscription rate, as an outcome of which the following resolution was carried by the meeting:

> That the present subscription of membership of the Queensland Branch of the B.M.A. be increased according to the following schedule:
>
> (*a*) The subscription of senior city members be raised from £5 to £5 10s. *per annum.*
>
> (*b*) That of senior country members, from £4 to £4 10s. *per annum.*
>
> (*c*) That of junior members, from £2 10s. to £2 12s. 6d. *per annum.*

The Honorary Secretary stated that this resolution, proposed by Dr. R. Quinn and seconded by Dr. J. L. Gibson, would have to be submitted for confirmation to the next general meeting of the Branch to be held in February, 1928.

Votes of Thanks.

Hearty votes of thanks were accorded to Dr. E. S. Meyers, the Honorary Secretary, and to Dr. F. A. Hope Michôd, the Honorary Treasurer, for the manner in which they had carried out the duties connected with their offices.

SCIENTIFIC.

A MEETING OF THE QUEENSLAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION was held at the B.M.A. Rooms, Adelaide Street, Brisbane, on November 4, 1927, DR. H. V. FOXTON, the President, in the chair.

Pityriasis Rosea.

DR. J. W. HEASLOP showed a patient who was suffering from *pityriasis rosea*. He described the condition and discussed the differential diagnosis.

Diet.

DR. E. SANDFORD JACKSON then read a paper entitled: "Notes on Diet" (see page 905).

DR. W. N. ROBERTSON, in thanking Dr. Jackson for his interesting address, said that the paper was very sane and sensible. He (Dr. Robertson) was very interested in the question of the apparent degeneration of the teeth of young Australians and thought that dental inspection should be begun at the earliest possible age. He referred to the probable influence of carbohydrates on the teeth and mentioned Scotland, where, he said, teeth were good as a rule. He also referred to faulty dental opposition as a possible factor conducing to dental decay. He spoke of the good influence of sunshine on the metabolism and on the health generally and advocated a hard diet rather than the soft, squashy *régime* which too often obtained in this country. The aboriginals had had good teeth, but since their adoption of the white man's dietary their teeth were not so good. Rough food and thorough mastication were in his opinion important factors in the maintenance of both dental and general health and he regarded the subject as most interesting, especially for the physician.

DR. F. A. HOPE MICHÔD congratulated Dr. Jackson on his paper which he also had found very interesting. He said that he had come from the south of England and had never seen a dentist until he came to Australia. He thought that the consumption of tank water conduced to the decay of children's teeth. *A propos* of water, he mentioned an interesting case in his experience of a man who had lived on nothing but water for forty days and had reduced thereby from 113 kilograms (eighteen stone) to something between 75 and 81 kilograms (twelve and thirteen stone). The man's very rigid dietetic *régime* had apparently made little difference to him.

DR. W. N. MARKWELL was eager to thank Dr. Jackson for his very instructive paper. Referring to the effect of milled wheat, he quoted an epidemic of beri beri that had occurred in a certain part of Queensland following a drought, during which people were compelled to live on "damper" only, made, of course, from milled wheat.

DR. J. LOCKHART GIBSON thanked Dr. Jackson for his address. It was always interesting to him to hear an account of a man's own experience. Where people depended on tanks for their water supply, he suggested liming tanks to supply lime to the water. With regard to dental health and hygiene, he thought it was work and stimulation the teeth needed for their better nourishment.

DR. J. BOSTOCK believed that, at the recent Dental Congress, the members had been unanimous about the value of chewing. He thought that an important point on the subject of diet was that of the cooking and preparation of foods. In European countries, for example, the cooking and preparation of food was quite a ritual and a very serious matter. Food on the other hand, in most Anglo-

Saxon countries was neither tasty nor appetizing. The psychological side of food and feeding was also a very important one and he stressed the psychic factor in dietary.

DR. E. S. MEYERS added his quota of thanks to the reader of the paper. The important things in his opinion were the quality, the quantity and the methods of use of the various foodstuffs. The important question was the selection of food and the manner of using it. He referred to a few small experiments he himself had done in this regard (i) in the case of trainees in a military camp and (ii) in the case of women after pregnancy and childbirth. He was interested in Dr. Michôd's point of conditions in the west, especially as this bore out his idea about the necessity of associated and cooperated investigation and research.

DR. P. J. KERWIN was anxious to compliment Dr. Jackson on his paper. In his opinion Australians suffered from over-civilization. On the dietetic side this showed itself in too much cooking and the preparation of all sorts of soft, squashy foods for consumption.

DR. C. E. TUCKER thanked and congratulated Dr. Jackson. The thing apparently stressed by the meeting was the effect of diet on the teeth; he thought there were many other things to be considered. He then went on to compare, *à propos* of the remarks on aboriginals and white men, the comeliness of the white matron of fifty with the decrepit old black hag of the same age. He concurred with regard to the excess of carbohydrate eaten by the average child and then referred to the high food value of butter which, if uncooked, contained vitamin and was so easily assimilated.

Dr. Tucker was of the opinion that children should be given much more butter. With regard to the question of a dietary suitable for Queensland, he said that this matter had not as yet been sufficiently considered. He compared, for example, conditions obtaining in Victoria and Queensland and asked should there not be a difference in dietary. He asked whether in Queensland a diet proper and suitable to the climate was adopted.

DR. E. S. MEYERS then asked the reader of the paper why it was that people usually gained weight after typhoid fever.

DR. D. A. CAMERON also thanked Dr. Jackson for his paper. He averred that he himself had always been more or less worried about the question of diet. He referred to the healthy children living in the district where he practised; these children, he said, ate much the same as their parents. He thought that poor children seemed healthier generally than the children of the well-off. He referred also to the psychic effect of eating and said that introspection was not good for digestion. He was a great believer in what Dr. Jackson had called the "patient's own feelings" and believed neither in forcing patients to eat, nor in withholding food from them when they wanted it. The point he wished to stress was not to force patients to eat, but to go by their appetite and desire. He considered the question of diet a very big and full one and thought that much really depended on the individual patient.

DR. C. F. DE MONCHAUX expressed the opinion that, from his observations it did not seem to matter so much what was eaten as to what happened to what was eaten or how the body dealt with what it received in the way of fuel. He cited as examples the dietaries of Greenlanders and Italians, so different from that of Australians, which apparently agreed quite well with the inhabitants of those countries and did not prevent them from becoming good workers and citizens. The adaptability of the human body was a very important point, especially with regard to this much discussed subject of dietetics. If they were present in the food taken, the body seemed to extract and assimilate the ingredients and substances necessary to its life and well-being. It was not the consumed petrol so much, but the consuming machine that seemed to matter and to make all the difference. He mentioned the classical case of one Nebuchadnezzar who from all accounts had lived for quite a long time on nothing but grass and had apparently survived. In modern times also the much-maligned "vegetarian" seemed to thrive and to survive on such things as "nut cutlets" and the like. Provided the proper materials were there, it did not seem to matter much whether one fed on the much sought after "*pâté de foie gras*" or the more common and everyday "*je ne sais quoi.*"

DR. H. V. FOXTON then thanked the reader and congratulated Dr. Jackson on his versatility and on the interesting discussion his paper had provoked. He referred to dental caries and to pyorrhœa and to the influence of diet on these conditions. He hoped there would be instituted a "good food campaign" later on when the present cancer campaign was properly established. He mentioned the very possible detrimental influence of the tooth-brush on the health of the teeth and the subsequent development of pyorrhœa. He regarded the filthy and ubiquitous tooth-brush as a most important and considerable factor in the ætiology of dental disease generally and of pyorrhœa in particular.

DR. E. S. JACKSON, in reply, said that he was glad if his paper, as it appeared, had made his audience think. With regard to Dr. Robertson, he said that the claim that Scotchmen had good teeth and owed them to the fact that their chief article of food was oatmeal, was certainly justified some years previously. But it was not so at the present day. Scotch people had as bad teeth as any other nation and they probably owed them partly to over-refined oatmeal. While agreeing with Dr. Robertson that sugar might have a big influence on teeth, he thought that sugar and carbohydrates could scarcely be blamed for the present degree of dental decay. Negroes working on American plantations had good teeth and their diet was largely sugar, but not a refined white sugar such as was loved and used today. It would seem, he added, that raw, rough foods were consumed by most races which had good teeth. Australian aboriginals had had good teeth till they gave up native foods and took to civilized foods. Incidentally, also, the change from nakedness to the wearing of clothes had increased their tendency to catarrhal conditions. Most speakers had referred to eating many things raw; they would derive advantage, he thought, from a larger consumption of such things as raw salads. Concerning obesity, he thought there was no better cure than starvation. The idea of lime-washing roofs, mentioned by one speaker, in order to provide a greater mineral content in tank-water, contained in his opinion some wisdom. He had for years kept mental note of the environment of such adults as came under his notice with a full mouth of sound teeth. They came from country districts—the Hunter or the Burnett districts for instance—and in their youth had drunk water from running streams or springs, not water from a galvanized tank. Two exceptions he cited—two brothers born at Stanthorpe, who had at thirty or thirty-five years of age, the most perfect teeth. They had drunk tank water from their youth up; but it was likely, he explained, that every vegetable, even the grass grown in the Stanthorpe district, was highly mineralized. Even the sheep, cattle and horses of the district were probably well supplied with minerals which they passed on to those who ate them. Regarding Dr. Meyer's question as to why convalescents from typhoid got fat, he thought it was due to the great alimentary rest such patients had had with cleansing of the digestive organs and resultant improved digestion. In regard to obesity, he referred to the obesity of adolescents (girls) and the later obesity in women of thirty-five or so. This obesity in women was closely associated with the menstrual function and the "middle-aged spread" of both sexes might also indicate a similar association with sexual function. He often deprecated the reduction of weight in patients; frequently the patient was not so well afterwards as before. In regard to Dr. Gibson and aboriginal foods, he pointed out that the aborigines did not overcook their food. He strongly deprecated overcooked things, such as beef. So-called well-done beef or mutton often consisted of an outside layer of "cinder" and inside layers of the colour and consistency of shoe-leather which were little more digestible than so much boot. Illustrating the effects of food-deprivation, he referred to the interesting experiences of some of the early navigators, mentioning especially Bligh's voyage of three thousand miles with eighteen men, all of whom were allowed two or three twenty-fifths of decayed biscuit per day. They survived the most dreadful hardships and food restriction and could not have lived but for the fact of frequent rains during their voyage. He supported Dr. Tucker in his

advocacy of cream and butter. No one, he said, had mentioned alcohol in talking of food. He ascribed in conclusion a good deal of dental harm to the tooth-brush which, he added, was unknown among aboriginals.

A MEETING OF THE VICTORIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION was held at the Pathological Department of the University of Melbourne on November 7, 1927. The meeting was arranged by the Branch and the Permanent Committee for Post-Graduate Work and took the form of a series of demonstrations.

Disease of the Gall Bladder.

MR. C. J. O. BROWN demonstrated the pathological changes of gall bladder disease. He said that the possible modes of infection were by lymphatics, blood vessels and bile ducts. Some observers held that cholecystitis was almost invariably associated with pericholangitis in the liver and that most cases of cholecystitis arose by lymphatic spread from the liver which had previously been infected from some focus in the portal area, for example, the appendix or the spleen. The lymphatics of the gall bladder were intimately associated with those of the duodenum and this suggested direct lymphatic spread in cases of cholecystitis associated with duodenal ulcer. The frequency with which infection was most pronounced in the subperitoneal area of the gall bladder, was very suggestive of lymphatic infection since the lymphatics ran in the peripheral coats of the gall bladder. Direct infection from the liver through the bile or from the duodenum was less certain. It was difficult to infect the mucous membrane of the gall bladder experimentally by injecting organisms into its lumen and in enteric fever, although the bile was invariably infected, cholecystitis was uncommon. Blood infection had been ably advocated by Rosenau who had demonstrated the specific localization of streptococci.

In the formation of gall stones three factors had to be considered: (i) Infection which was responsible for the ordinary mixed calculi which were just an incident in the cholecystitis; (ii) metabolic defect which resulted in the formation of the pure cholesterol stones and probably also the pigment stones, these stones being frequently found in non-infected gall bladders; (iii) stasis which was probably a factor of minor importance and was chiefly responsible for the growth of stones in the ducts around a nucleus; this was usually a gall bladder stone which had become impacted in the duct.

Gall bladder disease could be divided into three pathological groups:

1. Stones without cholecystitis as in the pure cholesterol stone which might produce no symptoms or might cause recurrent attacks of colic. Infection sometimes supervened after impaction in the neck of the gall bladder.

2. Cholecystitis without stones giving rise to symptoms of reflex dyspepsia.

3. Cholecystitis with stones giving rise to the same symptoms as in Group II with in addition the complications due to stones such as colic (this could also occur without stones), obstruction, carcinoma and fistula formation.

The functions of the gall bladder and the physiological and pathological basis of cholecystography were briefly discussed and specimens were shown to illustrate the various types and complications of gall bladder disease.

Chronic Nephritis.

DR. S. V. SEWELL showed a number of specimens illustrating different forms of chronic nephritis. An ætiological classification of this disease was not possible, as in most cases the cause was not known. The *post mortem* appearances of the kidney represented merely the end result of a long standing process and not the stages by means of which that result was obtained and were therefore not satisfactory as a basis for classification. It was therefore necessary to rely on a clinical classification based on symptoms and functional tests. In some cases of chronic nephritis the vascular and epithelial elements were evenly affected. Using these as a starting point all grades of change could be seen, passing on the one hand to the small white smooth kidney which was probably an abiatrophy with little or no fibrotic change, and on the other to the typical arteriosclerotic kidney. The small contracted white kidney gave a fairly typical clinical picture, usually in a young patient, with a sudden onset of uræmic manifestations.

Tests of Renal Efficiency.

DR. BASIL CORKILL gave a short lecture on the various tests for renal efficiency and demonstrated by means of appropriate apparatus the way in which they were carried out. The estimation of the urea content of the saliva was fully explained and demonstrated and it was pointed out that the percentage of urea in the saliva ran approximately parallel to that in the blood. The sulphosalicylic acid test for albumin in the urine was very simple and reliable and Dr. Corkill thought that it was worthy of more general application. He also demonstrated the method of estimating the percentage of urea in the urine by means of the hypobromite method.

The Regurgitative Group of Gastric Symptoms.

DR. FRANK APPERLY gave a demonstration illustrated by museum specimens and diagrams on the physiology and pathology of that group of gastric symptoms called the regurgitative group, namely nausea, vomiting, eructations *et cetera*. Whereas vomiting was due to stimulation of the vomiting centre from many organs *viâ* the cranial, cranio-bulbo-sacral and sympathetic group of nerves and from psychic and central causes, other regurgitative symptoms seemed to depend on some depression in the metabolism of the gastro-intestinal muscle itself. Anything that interfered with the supply, carriage, or utilization of blood and oxygen supply to gastro-intestinal muscle would produce these symptoms. The importance of these facts in the diagnosis of the ultimate cause of these symptoms was clearly shown.

Tumours of the Testicle.

MR. HAROLD DEW showed and demonstrated specimens illustrating the pathology of the various types of testicular neoplasms, including two rare types of teratogenous sarcomata. The macroscopical pathological changes and their correlation with signs and symptoms were briefly described. The prognosis as based upon rate of growth, microscopical appearance and the formation of metastases was also discussed. Following this introduction, particular stress was laid upon the difficulties of diagnosis from other scrotol swellings and a series of interesting diagnostic cases was illustrated by appropriate specimens. These included the following: (i) Hæmatocœle of the *tunica vaginalis*, (ii) hypertrophic fibrocaseous tuberculosis, (iii) tuberculosis of an anteverted testis, (iv) gumma of the testis, (v) lipoma of the scrotum, (vi) fibro-sarcoma of the retrotesticular connective tissue arising from the *gubernaculum testis*, (vii) mildly infected chronic hydrocœle.

In all of these Mr. Dew laid stress on the importance of palpation of the epididymis, of needling the *tunica vaginalis*, of the history, of eliciting if possible the testicular sensation and of exploration if doubt arose.

The Pulmonary Sequelæ of Measles and Whooping Cough.

DR. G. A. PENINGTON showed a number of specimens illustrating the pulmonary sequelæ of measles and whooping cough. He considered that it was not at all uncommon both in children and adults for chronic pulmonary disease to begin after an attack of one of the above mentioned conditions or influenza. In some cases bronchiectasis was present and in others subacute or chronic inflammation of the lung tissue. A number of specimens both macroscopical and microscopical, illustrating the above changes, was demonstrated.

Fibrocystic Disease of Bone and Allied Conditions.

DR. HAROLD MOORE showed and demonstrated a number of specimens and skiagrams illustrating the features of fibrocystic disease, *osteitis deformans*, osteomalacia, rickets and congenital syphilis of bone. A very interesting

example of sarcoma supervening on *osteitis deformans* was also exhibited.

Liver Atrophy, Regeneration and Carcinoma.

DR. G. F. S. DAVIES showed a number of specimens, both macroscopical and microscopical, illustrating acute and subacute atrophy, multiple nodular hyperplasia, cirrhosis and primary carcinoma of the liver. In acute atrophy death usually took place in a very short time and there was very little if any evidence of regeneration. In subacute atrophy regeneration of liver cells and bile ducts could be seen, but atrophic processes predominated and the duration of the disease was a few weeks to a few months. In multiple nodulra hyperplasia, although definite destruction of liver cells took place, there was also present considerable regeneration of liver cells forming adenomatous nodules and also numerous new bile ducts. The connective tissue present was very cellular and embryonic in type and the whole course of the disease was usually a few months to one or two years. Cases were seen presenting all grades of transition between multiple nodular hyperplasia and portal cirrhosis, the macroscopical and microscopical features which were demonstrated. Most if not all cases of primary carcinoma of the liver developed on the basis of a preexisting cirrhosis and many pathologists doubted a diagnosis of primary carcinoma if cirrhosis was not also present.

The Prostate.

MR. BASIL KILVINGTON showed a number of specimens illustrating the pathology and clinical features of diseases of the prostate.

Bone Tumours.

PROFESSOR MACCALLUM showed a number of specimens illustrating the features, both macroscopical and microscopical, of bone sarcoma. He agreed with the classification of such tumours adopted by the Registry of Bone Sarcomas, America, and described by Kolodny in a recent number of *Surgery, Gynecology and Obstetrics*. Primary malignant bone tumours could be divided into four groups: (i) Osteogenic sarcoma, (ii) Ewing's sarcoma, (iii) myeloma, (iv) a group of unclassified sarcomata, including amongst others angio-endothelioma and extraperiosteal sarcoma.

The osteogenic sarcomata were derived from the ancestors of cells which when fully developed were known as osteoblasts and might therefore show all stages in the further development of these cells from the simple spindle cell to mucoid, cartilage and even true bone.

Ewing's sarcoma affected young patients, rarely above twenty-one years of age. It frequently began with features simulating acute osteomyelitis. Metastases occurred and in some cases response to radiation was remarkable. Histologically it consisted of small polyhedral cells with round or oval nuclei and scanty non-staining protoplasm. A prominent feature was the absence of intercellular substance. Ewing had suggested an origin from the endothelium of bone marrow.

Myelomata were usually multiple, originated in the medullary cavity and were derived from the bone marrow cells of the myelocyte series. The giant cell tumour of bone (so-called myeloid sarcoma) was essentially benign in character. The structure of the different varieties of giant cells seen in pathological conditions was briefly discussed, namely, the foreign body giant cell seen in syphilis and tuberculosis, the giant cell seen in rapidly growing tumours and the giant cell of so-called giant cell sarcoma.

A MEETING OF THE VICTORIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION was held at the Physiology Department, Melbourne University, on November 9, 1927. PROFESSOR W. A. OSBORNE and his staff gave a series of demonstrations.

Venous Pressure and the Failing Heart.

Professor Osborne's first demonstration was designed to illustrate the fact that so long as the heart remained in good condition, even pronounced changes in the arterial pressure were accompanied by very little alteration in the venous pressure, but in the presence of heart failure a rapid rise in venous pressure occurred. A slight rise in the pressure in the great veins in the neck resulted in a reflex quickening of the cardiac rate as had been shown by Bainbridge. A dog had been prepared before the demonstration. Both vagi had been cut. Curare had been given. The venous and arterial pressures were recorded on a revolving drum by means of cannulæ inserted into a femoral vein and passed right up to the *vena cava* and also into the carotid artery. intratracheal anæsthesia had been established. The radial nerve was first stimulated. A rapid rise in arterial pressure followed, but there was very little alteration in the venous pressure.

Trinitrin 1·2 milligrammes (one-fiftieth of a grain) was then injected and a rapid fall in arterial pressure resulted, but again there was very little effect on the venous pressure. Professor Osborne pointed out that drugs, such as the organic nitrates and the inorganic nitrites which dilated blood vessels, were apt to weaken the heart muscle. Five cubic centimetres of one in one hundred thousand solution of adrenalin were then injected. There was a very steep rise in arterial pressure and a slight but definite rise in venous pressure. This slight rise in venous pressure might have been partly due to cardiac embarrassment. In most cases after the injection of adrenalin no rise in venous pressure occurred.

The vagi were then stimulated, first the right and then the left and in each case cardiac stoppage with a definite rise in venous pressure resulted.

Asphyxia was then induced. Owing to the stimulation of the medulla by means of the asphyxial blood a definite rise in arterial blood pressure with large excursions occurred. The venous pressure manifested very little alteration until heart failure supervened, when it rapidly rose. The air was then turned on again and as the heart recovered the venous pressure rapidly fell.

The Hot Wire Method of Recording the Pulse and Apex Beat.

Professor Osborne then demonstrated the hot wire method of recording the velocity of the pulse wave. He pointed out that the method could be used to record anything that could be translated into a puff of air, for example, the movements of the larynx and the venous pulse in the neck. The apparatus used consisted of a portable string galvanometer connected to a Wheatstone's bridge, one arm of which consisted of a coil of wire heated by an electric current and the other of a variable resistance. The slightest puff of air passing over the wire would cool it, thus causing an alteration in resistance with a corresponding deflection of the "string" galvanometer. Professor Osborne thought it possible that by means of this aparatus a differentiation might be made between the rigidity of the arterial wall and the pressure of its contents.

Amplification of Heart Sounds.

Professor Osborne then asked Mr. Slater to demonstrate an apparatus for the amplification of heart sounds. The "pick-up" device was of the electro-magnetic type, coupled directly to the chest wall, thereby avoiding any distortion and losses that would result from using air as a conducting medium. Another great advantage of this type of "pick-up" was that it was insensitive to sounds in air, so doing away with extraneous sounds and also permitting the loud speaker to be placed nearby. The sound vibrations, having been converted into minute oscillatory currents, were then led to the amplifier which consisted of four valves and had an amplification of ninety transmission units which were equivalent to a power amplification of one thousand million times. The electrical impulses after amplification were then passed to a loud speaker of the cone type which converted them into sound waves in air of sufficient amplitude to be heard by the audience in the lecture theatre. Mr. Slater pointed out that ordinary loud speakers of the horn type were not suitable for reproducing sounds of low frequnecy like the heart sounds. The "pick-up" device was the most difficult part of the

apparatus to design. In order to maintain purity of reproduction sensitivity had to be sacrificed, hence the need for powerful amplification. The apparatus was capable of further improvement and it was hoped that in the future a more extended use would result. Acknowledgement was made of the great help that had been given in this investigation by Mr. Witt, of the Post Office Research Department.

Applications of the Interferometer to Medicine.

The interferometer was a fairly new instrument. The one about to be demonstrated was, as far as Professor Osborne was aware, the first to be employed in a British school of Physiology and had been in use for over a year. It consisted essentially of two tubes in which were placed fluids or gases under investigation. Parallel beams of light were passed through each tube and then focussed by means of a convex lens. If one tube contained the slightest divergence in content from the other, there would be a corresponding reduction in the velocity of transmission and a shift in the "interference fringes." The apparatus had not been in use for a sufficient length of time to determine its practical utility. It might, however, be of great value in measuring quantitatively slight differences in the composition of any fluid or gas. It might form a ready means for estimating the carbon dioxide content of the alveolar air and the blood serum during pregnancy was being investigated by it.

Colloids.

A demonstration was also given of colloids viewed microscopically with the aid of the cardioid condenser.

Vote of Thanks.

At the conclusion of the demonstration a vote of thanks to Professor Osborne was moved by Dr. A. V. M. Anderson, seconded by Dr. R. R. Stawell and carried by acclamation.

Medical Societies.

THE MELBOURNE HOSPITAL CLINICAL SOCIETY.

A MEETING OF THE MELBOURNE HOSPITAL CLINICAL SOCIETY was held at the Melbourne Hospital on September 13, 1927. The meeting took the form of a series of clinical demonstrations.

Auricular Fibrillation.

SIR HENRY MAUDSLEY reported a case of medico-legal interest on which he had been asked to report from the point of view of employers' liability.

The man had been in the employ of the City Council for the previous five years as a labourer. For seven weeks prior to September 18, 1926, he had been employed in carrying pitchers to a bench to be dressed. During the five years of his employment he had not had any time off duty and as showing that his work did not fatigue him unduly, Sir Henry Maudsley said that he had worked for nine and three-quarter hours a day as well as often doing an hour overtime in order to earn more money.

On September 18, 1926, he had lifted slabs of stone 1·2 metres (four feet) long which were thus heavier than the stones that he usually lifted and this work had entailed considerable exertion. He stated that he felt something give way in his chest and had been unable to continue with his work. He had boarded a tramcar and had gone home where he had consulted a doctor who said that he had strained his heart. He had been sent to Saint Vincent's Hospital on September 19, 1926, where he had remained until October 5, 1926, in bed and later had attended as an out-patient, but he had gradually become worse, had experienced difficulty with his breathing and swelling of the legs. He had been readmitted to that hospital in December, 1926, and about 1,800 cubic centimetres (sixty ounces) of fluid had been withdrawn from his chest. He had been in bed on this occasion for five weeks. Since then he had been unable to work. Examination had revealed that he was a big man with an emphysematous chest and some enlargement of the heart. The heart sounds had been rapid and irregular and all the signs of auricular fibrillation had been present. There had been a systolic bruit over the mitral area. The blood pressure had been 170 millimetres of mercury at some beats, 120 at others and at some beats the pressure had not registered. The liver had not been enlarged and there had been no fluid in the chest. There had been some œdema of the legs.

Except for enteric fever in the nineties there had been no history of previous illness, no history of syphilis or of rheumatic fever.

Sir Henry Maudsley had seen him first six months after the "accident" and had been asked to report on the condition. He had reported that he might or might not have had some cardiac disability before September 18, 1926, but he certainly had had good reserve. He considered that the heart failure had supervened on September 18, 1926, and that probably the fibrillation had come on then, too.

In July, 1927, he had been asked to be present at another examination of the man. The doctor acting on behalf of the employers had been inclined to doubt that there was any auricular fibrillation. An electro-cardiogram had been taken and Dr. H. Hume Turnbull had reported that there was auricular fibrillation with a right branch block and had expressed the opinion that either (i) the patient had had auricular fibrillation before September 18, 1926, and the exertion of lifting the extra weight on that day had brought on the right branch block or (ii) the patient had at that time had a right branch block and that the exertion had brought on the fibrillation. Dr. Turnbull had considered that the second alternative was the more probable.

Sir Henry Maudsley went on to mention the cases reported by Hay of auricular fibrilation due to trauma and explained that the case was of importance because it was defended by an insurance company. Nine years previously the man had been examined when he had had a pain in the lower part of the abdomen and at that time no cardiac disability had been found. The trial had turned largely on what was an "accident."

The House of Lords had held that an accident was any unforeseen event occurring in the course of work (from the point of view of the worker's insurance) even if this event occurred within the man's body, as was exemplified in their decision in regard to liability for a ruptured aneurysm. Judge Foster in Melbourne in this case had stated in his judgement that he was not prepared to say whether there was a damaged heart before the "accident" on September 18, 1926, or not and had awarded the man full compensation.

DR. H. HUME TURNBULL said that there had been much discussion on Hays's paper and no proof was possible. He quoted a case of a man, sixty-eight years of age, who fifty years previously had had an attack of fibrillation and who had had many attacks since. This showed that attacks of fibrillation could occur and quite probably as the result of exertion.

DR. R. P. MCMEEHIN mentioned a case of a man whom he had seen two years previously on account of a pain in his back and whom he found to have auricular fibrillation. This man had not had syphilis or rheumatic fever and he had been aware that his pulse had been grossly irregular for at least thirty-five years.

DR. S. V. SEWELL spoke of a patient whom he had seen in 1910. The patient had then been water-logged and had had an irregular pulse, a typical auricular fibrillation. Since then he had taken 0·6 mil (ten minims) of digitalis daily and that had enabled him to work for nine years when he had contracted pneumonia during the influenza epidemic, recovered and was still working. He was still taking the digitalis and his heart was still fibrillating.

Case for Diagnosis.

DR. S. O. COWEN showed a female patient, aged twenty, who had been admitted to hospital on September 9, 1927, with the following history. Two months previously she

had been delivered of a healthy child at the Women's Hospital, the confinement had been normal and she had been discharged after ten days' stay in the hospital. She had remained quite well until fourteen days before admission to the Melbourne Hospital when she had suddenly developed a sharp pain in the lower part of the chest on the right side. The pain had been intensified by breathing deeply or coughing. The pain had not been persistent, but had recurred at intervals. It had not been accompanied by other symptoms until forty-eight hours before admission when she had had a shiver. Another shiver had occurred twenty-four hours before admission. During the day preceding the first shiver the pain had been severe, but since then had quietened down considerably.

Examination on admission had revealed flushing, a toxic appearance, a temperature of 40° C. (104° F.), a pulse rate of 108, respirations of 28 in the minute. The heart's apex had been in the fifth left interspace ten centimetres (four inches) from the midline; a soft systolic bruit had been present at the pulmonary area, but the sounds elsewhere had been normal. The liver dulness had been increased upwards, the percussion note being impaired in the third interspace anteriorly, in the second interspace in the mid-axillary line and to within 2·5 centimetres (one inch) of the lower angle of the scapula posteriorly. Over this dull area the breath sounds had been much diminished, but their pitch had remained unaltered and there were no adventitious sounds. Abdominal and pelvic findings had been normal and the urine had contained a trace of albumin, but there had been no abnormal formed elements on microscopical examination. A provisional diagnosis of right subphrenic abscess had been made. In spite of the normal gynæcological findings it had been thought that the primary focus was a pelvic one, probably a result of a low grade puerperal infection, either of the uterine or of the Fallopian tubes. X ray examination had been carried out after this diagnosis was made, the report being to the effect that the left lung was clear and that there was a definite excursion of the left side of the diaphragm. The right side had been almost immobile and generally raised. Some dulness had been present in the right lower lobe close to the spine extending from the hilus.

During the three days following the patient's admission to hospital the temperature had remained high and though the leucocyte count had been only 9,000 to 12,000, it had been felt that the evidence of the existence of a subphrenic abscess was conclusive. Mr. Dew had concurred and exploration under general anæsthesia had been performed on September 13, 1927. Needling the base of the right lung and the subphrenic space had yielded no result, so Mr. Dew had opened the abdomen as he felt that pus must be present somewhere in the upper part of the abdomen. Exploration had revealed no sign of any abscess; the liver had been elongated; the right half of the diaphragm had been unduly high and its movements restricted, but no pathological cause could be discovered for these abnormalities. The spleen had been of normal size. The patient had made an uneventful recovery from the operation and her condition had remained unchanged. The fever continued, but there had been no rigors since her admission to the hospital. The heart murmur had persisted, but there had been no other signs of infective endocarditis detected. The chest signs had been the same as at the first examination. In the hope of obtaining a clue as to the source of her toxæmia the following investigations had been made since operation. No agglutination had followed the Widal test. Urinary culture had yielded no organisms. Blood culture had been sterile. The leucocyte count had been 14,500 per cubic millimetre. Microscopical examination of the urine had revealed a very occasional red blood cell.

DR. H. HUME TURNBULL said that the skiagrams showed that the left lung was much more translucent than the right. The condition was probably an inflamed lung, the inflammation causing an infiltration round the bronchi and the patient would get well.

MR. VICTOR HURLEY suggested that the cause might be a perinephric abscess.

SIR HENRY MAUDSLEY also suggested a similar cause.

DR. LESLIE HURLEY said that there were two points of interest: (i) that he had seen patients with raised right diaphragm and diminished breath sounds who on exploration had proved to be normal, (ii) that he had seen a patient two years previously with a history of pleural pain *et cetera* who had had a perinephric abscess.

DR. R. P. MCMEEKIN considered that the right lung was abnormal; there was no need to suppose that there was a perinephric abscess.

Probable Pernicious Anæmia.

DR. L. E. HURLEY presented a male, aged thirty-seven, who at the age of thirteen had been operated on for a cyst in the region of the right shoulder which he stated had been thought to be a hydatid. There was no history of anæmia in the family. In 1920 he had been admitted to the Royal Prince Alfred Hospital complaining of weakness for the previous few months and bleeding *per rectum*. A diagnosis of pernicious anæmia had been made and under treatment with iron and arsenic he had apparently recovered.

In 1923 he had been admitted to the Melbourne Hospital complaining of the same symptoms. Blood examination at that time had revealed a red cell count of 2,550,000 per cubic millimetre, a hæmoglobin value of 30% and a colour index of 0·6. The stained film had manifested anisocytosis, poikilocytosis, a few myelocytes and no nucleated red cells. An examination of the fæces had revealed nothing abnormal. His condition had been diagnosed as secondary anæmia and he had been discharged with a red count a little under 3,000,000.

On February 27, 1925, he had been readmitted to the Melbourne Hospital complaining of weakness for the previous few months. A fortnight before admission his blood had been examined by Dr. Fitzpatrick who had found a red cell count of 750,000 per cubic millimetre and a colour index of 0·2. Under treatment with iron and arsenic he had improved considerably in the fortnight prior to his admission when examination of his blood had revealed the red cells to be 2,900,000, the hæmoglobin value to be 60% and the colour index 1·0. The test meal had revealed a total of 40 and a free acidity of 25. The diagnosis of pernicious anæmia had been made and on on his discharge the red cells had numbered just under 3,000,000 per cubic millimetre.

On May 31, 1927, he had been again admitted, complaining of palpitation as well as weakness for the previous seven months. There had been no loss of weight and no soreness of the mouth or tongue.

On examination he had looked very pale, but well nourished. The skin had manifested a definite lemon yellow colour. The tongue had manifested no glossitis and the edge of the spleen had just been palpable at the end of a deep inspiration. The Van den Bergh test had yielded a delayed direct positive reaction. A full clinical examination of the heart, lungs, abdomen, nervous system had revealed nothing abnormal. No reaction had been obtained to the Wassermann test, stereoscopic examination of the chest had revealed no abnormality, the fæces had been normal and the urine sterile on culture. No abnormality had been discovered by a Casoni test and an opaque meal; the fragility had been normal. Fractional test meal had yielded a free acid figure of 10 and a total acid figure of 30. Blood examination had revealed the number of red cells to be 900,000, the hæmoglobin value to be 30%, the colour index to be 1·66; no macrocytosis had been present. He had been given iron in the form of Blaud pills and arsenic in the form of *liquor arsenicalis* and dilute hydrochloric acid eight cubic centimetres (two drachms) every day.

On June 13, 1927, the red cells had numbered 1,100,000, the hæmoglobin value had been 30% and the colour index 1·4. The film had manifested definite macrocytosis and two megaloblasts after a prolonged search.

On June 25, 1927, the red cells had been 1,400,000 per cubic millimetre.

On June 30, 1927, a transfusion of three hundred cubic centimetres (half a pint) of blood had been given and an injection of sodium cacodylate 0·06 gramme (one grain) twice a week had been ordered.

On July 6, 1927, the red cells had been 1,900,000 per cubic millimetre, the hæmoglobin value 40% and the colour index 1·05.

On July 8, 1927, another transfusion of 120 cubic centimetres (four ounces) had been given.

On July 16, 1927, the red cells had numbered 4,000,000 per cubic millimetre, the hæmoglobin value had been 70% and the colour index 0·87. He had said that he felt better than he had done for years.

The points for discussion were:

1. The diagnosis. Dr. Hurley thought that the case was one of pernicious anæmia, although there were certain atypical features.
2. The fall in the colour index, the variation in the macrocytosis and the rapid improvement.
3. The question of treatment, especially as to the value of splenectomy. Pernicious anæmia was not a well defined disease, but a syndrome. Each case had to be considered individually as to the amount of hæmolysis, amount of abnormal blood formation and as to the degeneration in the heart and spinal cord. The question of hæmolysis depended on the degree of hæmolysis, for a diseased spleen caused more hæmolysis than a healthy spleen, for example, in syphilis, malaria and Banti's disease.
4. The results of splenectomy according to Mayo showed that there was a general group of atypical cases as yet classified as pernicious anæmia; in these hæmolysis was the paramount feature and the features were atypical, but a good result was obtained. These formed 10%. There was temporary benefit in nearly all patients and 22% lived beyond the life expectancy of those whose spleens were not removed.
5. The value of splenectomy in this case. Dr. Hurley thought that it would be advisable.

Dr. S. O. Cowen thought that the spleen should be removed. He was of the opinion that the usual statements that gross fibrosis of the spleen meant great hæmolysis was wrong. In hæmolytic cases the spleen was normal, except that it was stuffed with red cells and removal of the spleen in these cases resulted in cure, hence the cause of hæmolysis was probably chemical.

Dr. J. F. Wilkinson was loth to accept the diagnosis of pernicious anæmia in the presence of free hydrochloric acid and thought that the condition came under the head of hæmolytic anæmia. After all, what was pernicious anæmia? It could not be diagnosed from the film as a typical pernicious anæmia film was seen in other conditions such as malignant disease and certain cases of poisoning. With regard to the administration of arsenic he did not think that sodium cacodylate was much use, but preferred arsenic given by mouth or injections of "Novarsenobillon."

Dr. S. V. Sewell thought that the condition was probably not one of pernicious anæmia. At Rochester they rather inclined to the view that as regards splenectomy for pernicious anæmia the successes were obtained in obscure hæmolytic cases resembling pernicious anæmia and that this disease was a response of the bone marrow.

He recalled the case of two miners who had turned back from the north of Victoria, one of whom had died at Wangaratta, but the other had been able to reach Melbourne. He had manifested a typical pernicious film, but examination of the fæces had revealed the presence of ancylostoma and he had recovered on thymol being given.

Dr. L. Hurley, in reply, said that he considered that a fibrosed spleen caused more hæmolysis than a normal one. In this case he had given sodium cacodylate because the patient did not tolerate arsenic well by the mouth.

Results of Diathermy.

Dr. W. Kent Hughes showed several patients. The first was a boy who had received an injury to his *quadriceps extensor* muscle and four months later had reported with a hard mass at the site of the injury. The diagnosis of *myositis ossificans* had been confirmed by X rays. The condition had been treated with diathermy and had cleared up and the patient had remained well for eighteen months.

The second patient suffering from epithelioma of the cheek had been seen in February, 1927, when he had been treated with diathermy and in June, 1927, a thickening at the site had also been treated with diathermy. Dr. Hughes asked whether the glands should be removed.

The third patient was also suffering from epithelioma of the cheek which was treated with diathermy four years previously, but no glands had been palpable at that time. A year later he had reported with an epithelioma of the other cheek and that had also been treated with diathermy and four months previously he had had a lump in the floor of the mouth treated in a similar fashion. Thus there had been three distinct growths, but in none were there any palpable glands.

The fourth case was that of a man with an epithelioma of the tongue. The tongue had been fissured and the Wassermann test had yielded a positive result. Superficial diathermy had been used, but in six months a growth in the floor of the mouth further back had had to be removed by diathermy. At present the condition of the mouth and tongue was very satisfactory, but there was a gland palpable on the left side.

Special Correspondence.

LONDON LETTER.

By Our Special Correspondent.

Nitrous Oxide and Oxygen Anæsthesia.

To those interested in the administration of anæsthetics a few remarks concerning the latest admirable "Walton" gas-oxygen machines may be of value. One of the special advantages is that by moving a single lever nitrous oxide and oxygen can be administered either separately or in any desired proportions.

The anæsthetist can give his whole attention to the delivery of the exact proportion of oxygen to nitrous oxide required by the patient without having to keep an eye on the bags for fear either of them should become too full and burst or too empty. In the "Walton" the bags are automatically kept filled to exactly the required degree as set by the foot and equal to one another, with the result that the percentages are true. Unintentional alteration of the percentages, owing to the pressure being greater in one bag than the other, cannot occur, with the result that the anæsthesia is smoother and therefore can be maintained longer.

Extra attachments for ether, ethyl chloride and so forth can be supplied to go between the mixing stopcock and the large bore flexible tube. The concentration of ether is regulated by means of a lever on the inhaler. To simplify sterilization a special reversible bag for rebreathing alone can be plugged into the large bore flexible tube. The above mentioned special rebreathing bag can be fitted with an ethylchloride attachment if desired. Prices range from £22 10s. to £32.

For outfits for nitrous oxide, oxygen and ether combined, H. E. G. Boyle's can be well recommended. These are obtainable in portable sets from £16 and the whole apparatus is contained in a strong wooden box with a strap handle. The ether bottle is fitted with a new pattern mount, giving a finely graduated delivery of ether, either "blown through" or "blown over."

This apparatus is also made in a set suitable for hospitals. The parts are the same as in the portable set, but it has an all metal stand on castors. The price is £18 15s.

Mr. Frankis Evans, Anæsthetist to Saint Bartholomew's Hospital and to the Prince of Wales's General Hospital, writes that the so-called "sight feed" consists essentially of two tubes, one for gas and one for oxygen, which dip below water. Each tube has an equal number of perforated holes, so that relative quantities of gas and oxygen may be delivered. Attached to the machine is a chloroform and an ether chamber. The best known types are Boyle's and Magill's, the latter yielding warm ether.

The "free flow" machine, as typified by the "McKesson" in America and the "Walton" in England, consists of special reducing valves connected to bags, one bag for gas and one for oxygen. The gases are mixed after

exit from these bags. A non-return valve is fitted which also intermits the flow, so that the patient shuts off the supply of gases automatically at each expiration. An ether chamber is fitted and graduated rebreathing is a feature of the "McKesson" as well as an emergency oxygen valve.

In Mr. Evans's opinion the "free flow" type is superior to the "sight feed" for the administration of gas and oxygen only, but for upper abdominal work when a really large dose of ether is required for complete relaxation, he prefers Boyle's or Magill's.

The "free flow" machine is ideal for all surgery in which absolute relaxation is not required. It is easy to work and uses gas at the rate of about four and a half litres an hour. There is great scope for gas and oxygen and from the patient's point of view it is ideal. Premedication of morphine is essential for the easy administration of gas-oxygen alone and the dose should not be on the small side.

The Lectures of the Royal Colleges.

It may be of some interest to the readers of THE MEDICAL JOURNAL OF AUSTRALIA to know something of the origin and intention of some of the special lectures and demonstrations given under the auspices of the Royal College of Physicians of London and the Royal College of Surgeons of England. In many cases, of course, the terms of the original bequest or donation have had to be altered to suit modern conditions and the requirements of present day medical science, but as far as possible the wishes of the founders have been respected. The Royal College of Physicians contribute the following:

Lumleian Trust.

In the twenty-fourth year of the reign of Elizabeth, 1581, a Richard Caldwell (former President of the College) in conjunction with the Lord Lumley, founded the "Lumleian Lecture in Surgery." This was referred to in the annals as the "Chirurgical Lecture" and it is given yearly to this day.

Goulstonian Trust.

The Goudstonian Trust was founded by Goulston, a Fellow of the College, in 1632; he laid down that a lecture was to be read from time to time by one of the four youngest doctors in physic of the College and it was to be upon two or three or more diseases. The lecture was to be read some time between Michealmas and Easter, "on three days together, both forenoon and afternoon, on some dead body, which shall then and there be dissected for the diseases treated of and shall afterwards be buried."

Croonian Lectures.

In 1684, William Croone, a Fellow of the College, left at his death a plan for two lectureships. One of these was to be read yearly before the College of Physicians, with a sermon to be preached at St. Mary-le-Bow, and the other, on the nature and laws of muscular motion, was to be delivered annually before the Royal Society.

Dyster Trust (Baly Medal).

In 1866, Frederick Daniel Dyster, M.D., arranged for a gold medal to be awarded every alternate year on the recommendation of the President and Council of the College to the person (irrespective of nationality) "who shall be deemed to have most distinguished himself in the science of physiology during the two years immediately preceding the award."

Bradshaw Trust.

The late Mrs. Bradshaw, widow of William Wood Bradshaw, a member of the College, founded the "Bradshaw Lecture" in memory of her husband. This was in 1880 and she laid down that the lecture was to be delivered annually on August 18, the anniversary of Bradshaw's death, on some subject connected with medicine or surgery. The lecturer was to be appointed by the President of the College. Some ten years later the sanction of the Charity Commissioners was obtained to vary the date on which the lecture might be delivered.

Milroy Trust.

In 1886, Gavin Milroy, a Fellow of the College, founded by will a yearly lectureship of three or more lectures on state medicine and public hygiene, the President and Council of the College being given full powers in regard to the detailed arrangements. The College adopted the "suggestions" left by Dr. Milroy in regard to the subjects of the lectures and they are kept in print for the guidance of the lecturers. The yearly series comprises not less than three and not more than six lectures.

Weber-Parkes Trust.

In 1895, Herman Weber presented a certain sum of money to the College in trust to provide a prize to be called the "Weber-Parkes Prize," in memory of the late E. A. Parkes. This prize was to be awarded every third year upon some subject connected with the ætiology, prevention, pathology or treatment of tuberculosis. Under regulations adopted with the approval of the founder in 1914 the prize is now awarded for the best work already done in connexion with tuberculosis and is not restricted to this country.

Fitzpatrick Trust.

In 1901, Mrs. Fitzpatrick, desiring to perpetuate the memory of her husband, Thomas Fitzpatrick, a member of the College, founded a lectureship in "The History of Medicine." Two lectures are delivered annually at the College by a Fellow, chosen by the President and censors. The lectures are then printed and published in a separate book.

Oliver-Sharpey Lecture or Prize.

The Oliver-Sharpey Lecture or Prize was founded in 1904 by the late George Oliver, a Fellow of the College, in memory of the late William Sharpey, M.D., F.R.S. The appointment or award is made annually by the President and censors who decide whether a lecturer shall be appointed or a prize awarded. There is no restriction as to nationality and the lectures delivered must be published. The intention was to promote physiological research by observation and experiment and to encourage the application of physiological knowledge to the prevention and cure of disease and the prolongation of life.

Lloyd-Roberts Lecture.

David Lloyd-Roberts, of Manchester, who died in 1920, founded an annual lecture—to be called the Lloyd-Roberts Lecture—on a subject of medical or scientific interest. Similar arrangements having been made by him with the Medical Society of London and the Royal Society of Medicine, it was finally decided that the three bodies concerned should combine and that a lecturer should be nominated annually by each in turn.

Correspondence.

TREATMENT OF VARICOSE VEINS BY INJECTION.

SIR: Major-General T. M. Corker in *The British Medical Journal* asks for information regarding the treatment of varicose veins by injection and if there is any danger from thrombosis. The Continental authorities on this treatment say they have never seen any ill effects such as inquired about and this indeed is borne out by my own experience after having done many cases here and observed many more in France. All my cases have shown satisfactory results and two cases of ulcer after the treatment completely healed. The treatment is almost painless and involves no inconvenience to the patients, allows them to follow their ordinary occupations and I have treated them all at my rooms. Bandages or stockings may be dispensed with and patients express complete satisfaction. A cure is the invariable result. I have noticed that those so treated have improved in general health and

lose that depression which is so common to those suffering from this affection.

In THE MEDICAL JOURNAL OF AUSTRALIA of November 19 under "Current Comment" the treatment of this complaint by injections is discussed. Professor Sicard, to whom I am indebted for most of my information and for the technique on this subject, does not hold with any hard and fast rule as to the sclerosing agent to be used and believes in every case being treated according to its history. This is also the opinion of Dr. Gaugier, whom I have seen use as many as three different agents according to the history of the individual cases. Of the great number of cases that I have seen I notice that a patient occasionally feels faint, but this usually occurred at the first treatment and may be put down to a nervous symptom. In my own practice I have had it occur once only and the patient soon recovered. I agree with Douthwaite who has written a work on this treatment and who says: "It is to be hoped that those intending to employ it will first master its principles; otherwise one can foresee some awkward complications following its use by inexpert hands" and thus bring discredit on a treatment of considerable value.

Yours, etc.,

A. LEWIS LEVY.

219, Macquarie Street, Sydney.
December 4, 1927.

Books Received.

PRACTICAL GUIDE TO DISEASES OF THE THROAT, NOSE AND EAR FOR SENIOR STUDENTS AND JUNIOR PRACTITIONERS, by William Lamb, M.D., C.M. (Edinburgh), M.R.C.P. (London), Revised by Frederick W. Sydenham, M.D., C.M. (Edinburgh), F.R.C.S. (Edinburgh), D.P.H. (Victoria); Fifth Edition; 1927. London: Baillière, Tindall and Cox. Crown 8vo., pp. 466, with illustrations. Price: 12s. 6d. net.

THE COMMON DISEASES OF THE SKIN: A HANDBOOK FOR STUDENTS AND MEDICAL PRACTITIONERS, by R. Cranston Low, M.D., F.R.C.P.; 1927. Edinburgh: Oliver and Boyd. Crown 8vo., pp. 235, with illustrations. Price: 14s. net.

A SHORT ACCOUNT OF THE ANTIQUITY OF HINDU MEDICINE, by David C. Muthu, M.D., M.R.C.S., L.R.C.P. (London); Second Edition; 1927. London: Baillière, Tindall and Cox. Foolscap 8vo., pp. 52.

PULMONARY TUBERCULOSIS: ITS ETIOLOGY AND TREATMENT, by David C. Muthu, M.D., M.R.C.S., L.R.C.P.; Second Edition, enlarged; 1927. London: Baillière, Tindall and Cox. Demy 8vo., pp. 503, with illustrations. Price: 12s. 6d. net.

Diary for the Month.

JAN. 3.—Tasmanian Branch, B.M.A.: Council.
JAN. 10.—Tasmanian Branch, B.M.A.: Branch.
JAN. 10.—New South Wales Branch, B.M.A.: Council.
JAN. 13.—Queensland Branch, B.M.A.: Council.
JAN. 16.—New South Wales Branch, B.M.A.: Organization and Science Committee.
JAN. 17.—Tasmanian Branch, B.M.A.: Council.
JAN. 17.—New South Wales Branch, B.M.A.: Ethics Committee; Executive and Finance Committee.
JAN. 18.—Western Medical Association, New South Wales.
JAN. 19.—Victorian Branch, B.M.A.: Council.
JAN. 24.—New South Wales Branch, B.M.A.: Medical Politics Committee.
JAN. 27.—Queensland Branch, B.M.A.: Council.

Medical Appointments.

Dr. Arthur Edward Harrison Salter (B.M.A.) has been appointed Government Medical Officer at Blayney, New South Wales.

* * * *

Dr. Percy Lewis Broadbent (B.M.A.) has been appointed Government Medical Officer at Forbes, New South Wales.

Medical Appointments Vacant, etc.

FOR announcements of medical appointments vacant, assistants, *locum tenentes* sought, etc., see "Advertiser," page xvi..

AUSTRALIAN INLAND MISSION: Flying Doctor for Cloncurry.

Medical Appointments: Important Notice.

MEDICAL practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

BRANCH.	APPOINTMENTS.
NEW SOUTH WALES: Honorary Secretary, 30 - 34, Elizabeth Street, Sydney.	Australian Natives' Association. Ashfield and District Friendly Societies' Dispensary. Balmain United Friendly Societies' Dispensary. Friendly Society Lodges at Casino. Leichhardt and Petersham Dispensary. Manchester United Oddfellows' Medical Institute, Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. North Sydney United Friendly Societies. People's Prudential Benefit Society. Phœnix Mutual Provident Society.
VICTORIAN: Honorary Secretary, Medical Society Hall, East Melbourne.	All Institutes or Medical Dispensaries. Australian Prudential Association Proprietary, Limited. Mutual National Provident Club. National Provident Association. Hospital or other appointments outside Victoria.
QUEENSLAND: Honorary Secretary, B.M.A. Building, Adelaide Street, Brisbane.	Members accepting appointments as medical officers of country hospitals in Queensland are advised to submit a copy of their agreement to the Council before signing. Brisbane United Friendly Society Institute. Stannary Hills Hospital.
SOUTH AUSTRALIAN: Secretary, 207, North Terrace, Adelaide.	All Contract Practice Appointments in South Australia. Booleroo Centre Medical Club.
WESTERN AUSTRALIAN: Honorary Secretary, 65, Saint George's Terrace, Perth.	All Contract Practice Appointments in Western Australia.
NEW ZEALAND (WELLINGTON DIVISION): Honorary Secretary, Wellington.	Friendly Society Lodges, Wellington, New Zealand.

Medical practitioners are requested not to apply for appointments to position at the Hobart General Hospital, Tasmania, without first having communicated with the Editor of THE MEDICAL JOURNAL OF AUSTRALIA, The Printing House, Seamer Street, Glebe, New South Wales.

Editorial Notices.

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